Psychiatric UR/QA Review Form

\*\*Please Complete & Submit all requested information at least 72 hours prior to date of Service\*\*

PROVIDER & FACILITY MUST BE IN NETWORK

For Benefits and Network Status call Boon-Chapman at 800-252-9653

Include the Following: Patient's History & Physical, Patients Clinic Records/Medical records pertinent to the request, Previous Treatment (including meds, therapy & Response to Treatment, Diagnostic Testing performed including the results).

**Patient Name:  Date of Birth: **

**Group:  Male /Female Patient Phone Number: **

**Ordering Physician **

**Contact Person  Tax ID **

**Address  Phone **

**Address  Fax **

**Visit authorized for evaluation Yes No Auth # **

**ICD Code(s): **

Psychiatric UR/QA Review Form

1. **Patient DSM-V diagnosis:  **
2. **Treatment Plan: Check all Modalities to be used.**

**90791 Psych Diagnostic Evaluation**

**90833 Psytx Pt/Family w/E&M 30 min**

**90836 Psytx Pt/Family w/E&M 45 min**

**90838 Psytx Pt/Family w/E&M 60 min**

**90832 Psytx Pt/Family 30 mins**

**90834 Psytx Pt/Family 45 mins**

**90837 Psytx Pt/Family 60 mins**

**90863 Pharmacologic Mgt w/Psytx**

**90853 Group Psychotherapy**

**90846 Family Psytx W/Patient**

**90847 Family Psytx W/O Patient**

**Other**

1. **Current psychotherapeutic medications and dosages:**

|  |  |  |  |
| --- | --- | --- | --- |
| Drug/ Jcode | Dose | Frequency | Duration |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. **Additional remarks to justify need for further treatment: **
2. **Number of Visits or Additional Visits Requested:**

**Frequency of Visits: Weekly Bi-Weekly Monthly PRN**