



**BlueCross
BlueShield
of Kansas***



For Medication Management Services

**Outpatient Treatment Request Form for Blue Cross and Blue Shield of Kansas
FAX REQUEST TO (913) 982-8176**

Date	Provider Name
Facility/Group Name	
Address	
Phone	Fax
Provider NPI#	
Client Name	
Date of Birth	Telephone Number
Certificate No.	Group No.
Insurance	

Diagnosis

Axis I	Axis I
Axis II	Axis III
Axis IV	Axis V (GAF) Current/Last Year

90805 # Requested _____

90862 # Requested _____

For 90807 requests, please fill out the two page Out-patient Treatment Request Form

Risk Assessment

Please rate the member using the following scale:

	High				Low
<u>Risk to Self or Others</u>	5	4	3	2	1
<u>Risk member will require a higher Level of care</u>	5	4	3	2	1
<u>Member's capacity to adhere to medical advice</u>	5	4	3	2	1

- Provide treatment goals: _____

- Provide medication and dosage: _____

- Are you coordinating treatment with the PCP? Yes No With other behavioral health providers? Yes No

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