Aetna Better Health®

CPST/PSR OTR FORM

Today's Date: _____ Type of Request: ☐ Initial Request ☐ Continued Stay Request	
Admit Date: _____ **This service requires prior authorization; authorizations will not be back dated.*	
Member Name: Member DOB: Medicaid/Health Plan #: Member Address: City, State: Zip: Member Phone #: Legal Guardian (if applicable):	If under 21, currently enrolled in CSOC? ☐ Yes ☐ No *If yes, please direct this request Magellan.* Currently enrolled in ACT? ☐ Yes ☐ No ICD-10 Code: Primary DSM Diagnosis Code:
Group/Agency Name: Address: Phone #: TIN #: Contact Name:	City, State: Zip: Fax Number: NPI #: Contact Phone #:
Contact Email:	
Current Treatment Request CPST	
HCPCS Code: ☐ **H0036**	Frequency (Times per week):
Service Start Date:	Total Number of Units:
All service requests will be authorized for 6 months	
Is this a PSH request (TG modifier)? ☐ Yes ☐ No	
Current Treatment Request PSR	
HCPCS Code: ☐ **H2017**	Frequency (Times per week):
Service Start Date:	Total Number of Units:
All service requests will be authorized for 6 months:	
Is this a PSH request (TG modifier)? ☐ Yes ☐ No	
Level of Member's Impairment:	☐ No Impairment ☐ Mild ☐ Moderate ☐ Severe
Progress Since Last Review:	☐ No improvement ☐ Minimally improved ☐ Much improved ☐ Very much improved

Aetna Better Health®

CPST/PSR OTR FORM

	☐ Initial request, not applicable
Member Name:	Member DOB:
For continued stay requests, describe for **LAST 30 DAYS** please describe functional impairment, , and engagement level in treatment(optional):	
Current symptoms that are the focus of current treatment (optional):	_____
Functional Impairment (optional):	_____
Progress (optional):	_____
Engagement level in treatment (optional):	_____
Printed LMHP/Provider Name and Credentials: _____ Signature of Provider/Clinician:	

Aetna Better Health®

CPST/PSR OTR FORM

Submitted by:	Date:
Member Name:	Member DOB:

PLEASE SUBMIT THIS FORM WITH THE FOLLOWING ITEMS:

For under age 21:

☐	CALOCUS/LOCUS (for 6 years and up) scoresheet signed by an LMHP, updated every 180 days, on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date
☐	Assessment signed by an LMHP updated every 180 days
☐	Treatment plan signed by an LMHP updated every 180 days including a crisis mitigation plan
☐	Signed Freedom of Choice form (Only requested on initial request or a change in provider)
☐	Progress Summaries (submitted for concurrent reviews only)

For age 21 and above:

☐	LOCUS scoresheet signed by an LMHP updated every 365 days, on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date.
☐	Assessment signed by an LMHP updated every 365 days
☐	Treatment plan signed by an LMHP updated every 180 days including a crisis mitigation plan
☐	Signed Freedom of Choice form (Only requested on initial request or a change in provider)
☐	Progress Summaries (submitted for concurrent reviews only)