Behavioral Health Outpatient Treatment Request

This Treatment Request form should be used by Outpatient Hospitals, Clinics, and Offices to notify MVP Health Care® of an MVP member receiving outpatient mental health and/or substance use treatment. Provide all required information and submit the completed form and supporting clinical documentation (assessment(s), treatment and medication information, progress notes, etc.).

Page 2, Outpatient Treatment Support Documentation, may be completed in lieu of providing supporting documentation.

Submit this completed request to MVP by email to bhservices@mvphealthcare.com or fax to 1-855-853-4850.

Section 1: Patient/Member Information

Member Name	Date of Birth	MVP Member ID No.	Phone No.

Street Address *Apt. No.*	City	State	Zip Code

Section 2: Requesting Provider Information

Requesting Provider Name	NPI No.	Tax ID No.	MMIS No.*

Street Address	City	State	Zip Code

Office Contact Name	Phone No.	Fax No.

Provider Group Affiliation Name *(if appropriate)*	NPI No.	Tax ID No.

Street Address	City	State	Zip Code

Section 3: Treating Provider Information

☐ *Same as Requesting Provider information above.*

Requesting Provider Name	NPI No.	Tax ID No.	MMIS No.*

Street Address	City	State	Zip Code

Office Contact Name	Phone No.	Fax No.

Provider Group Affiliation Name *(if appropriate)*	NPI No.	Tax ID No.

Street Address	City	State	Zip Code

Section 4: Clinical Information

Start Date of Services	Is this Request for Out-of-Network Services *(If **Yes**, supporting rationale required for Members without out-of-network benefits)*	☐ **Yes** ☐ **No**

Behavioral Health Diagnosis

Type of Treatment(s)

- ☐ Mental Health
- ☐ Eating Disorder
- ☐ Substance Use
- ☐ Dual Diagnosis
- ☐ Other:

Services Requested

- ☐ PHP
- ☐ IOP
- ☐ TMS
- ☐ ECT
- ☐ OP Therapy
- ☐ OP Med Visits
- ☐ Psych/Neuropsych Testing
- ☐ Other Outpatient:

CPT/HCPCS Code(s)

**Required if treating an MVP Medicaid or MVP Child Health Plus Member.*

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Member Name	*Date of Birth*	*MVP Member ID No.*

Behavioral Health Outpatient Treatment Supporting Documentation Information

The following information may be provided in lieu of including supporting documents with this request.

Medical Necessity Information

Chief Complaint

Out-of-Network Rationale *(if indicated)*

Current Medications *(including route, dosage, and frequency)*

Previous Medication Trials *(for TMS and ECT requests)*

Current Treatment *(not including this request)*

Treatment History

Treatment Plan

Focus/Goals of Treatment

Medications Changes *(if indicated)*

Collaboration with Family and Other Supports

Coordination of Care with Other Providers

Barriers to Treatment Completion/Discharge

Name of Person Completing Request (print)	*Signature*	*Date*