The Holman Group
Managed Behavioral Health Care Services

Assessment/ Request for Treatment
Follow-up Authorization *(for initial MD visit only)*

Patient Name: _____ Insured: _____

Insured's SSN: _____ Relationship: _____

Patient Phone: _____ Alt. Phone: _____

Employer/ Union: _____ DOB: _____ Age: _____

Provider/ Facility: _____ Provider/ Facility Phone: _____

Address: _____

City: _____ State _____ Zip: _____

Mental Status Exam
(Please check appropriate box for each category)

Orientation:	☐Intact	☐Impaired	☐Date	☐Place	☐Time	☐Situation
Appearance:	☐Well-groomed	☐Disheveled	☐Bizarre	☐Inappropriate		
Motor Activity:	☐Calm	☐Hyperactive	☐Agitated	☐Tremors/Tics	☐Muscle Spasms	
Speech:	☐Normal	☐Slowed	☐Pressured	☐Slurred	☐Stuttering	
Thought Process:	☐Intact	☐Circumstantial	☐Tangential	☐Flight of Ideas	☐Loose Associations	☐Confused
Mood:	☐Appropriate	☐Depressed	☐Anxious	☐Euphoric		
Affect:	☐None	☐Labile	☐Expansive	☐Constricted	☐Blunted	
Hallucinations:	☐None	☐Auditory	☐Visual	☐Olfactory	☐Command	
Delusions:	☐None	☐Persecutory	☐Grandiose			
Memory:	☐Intact	☐Impaired	☐Immediate	☐Recent	☐Remote	
Judgement:	☐Intact	☐Impaired	☐Mild	☐Moderate	☐Severe	

DSM-5/ICD-10

Mental Health/ Treatment History

Medication History

Medications, Dosage, Frequency, and Start Date

Received informed consent for medication: ☐Yes ☐No ☐N/A Any Allergies? ☐Yes ☐No

List all dates of service utilized during and beyond the current authorization period (specific dates):

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Type of treatment requested: Medication Mgt.

Med. Mgt. w/Therapy: ☐99213 ☐99214 ☐90833 ☐90836 ☐Other:

Dates: Requesting: From: _____ To: _____ Frequency: ☐Weekly ☐Monthly ☐Annually Other: _____

Brief narrative of patient's current complaints and coping strategies:

Drug & Alcohol Current Use and History: ☐None ☐Use ☐Dependence ☐Abuse ☐12 Step ☐Inpatient Treatment _____ ☐Outpatient Treatment _____

Substance(s)	Quality	Frequency	Date of Last Use	Duration of Use	# of Attempts at Recovery	Type CD Treatment

Treatment Plan			
Current Symptom *(i.e. sleep disturbance, poor concentration, decreased appetite,*	**Intervention** *(i.e. medication mgt., cognitive restructuring, guided imagery, reframing,*	**Target Date**	**Estimated Termination Date**
1.	1.		
2.	2.		

Use of Adjunctive Therapies: outpatient therapy, self-help programs, etc. (e.g. Alcoholics Anonymous):

Recommended Referrals: _____

I have coordinated care with other treating providers: ☐Yes ☐No ☐N/A Name: _____

To request referrals under the patient's mental health benefits, please call The Holman Group at (800)321-2843.
I certify that the above is true and correct:

Provider Name: _____ Date: _____

Provider Signature: _____

Authorization is hereby given to Provider to release to The Holman Group any information which he/she deems necessary to evaluate for insurance purposes.

Patient/Guardian Name: _____ Date: _____

Signature of Patient/Guardian: