



Quest Behavioral Health Outpatient Recertification Form Fax the completed form to: 717-851-1414

Provider and Member Demographics:

Patient Name: _____

Date of Birth: ____/____/____ ID#: _____

Insurance Plan: _____

Provider Name: _____

Office/Site: _____ Phone: _____

Risk Assessment:

Please rate the patient's current status on these symptoms, if applicable.

If not applicable, no response is necessary.

Table with 6 columns: Ideation, Plan, Prior Attempt, Prior Ideation, None. Rows: Suicide Ideation, Homicide Ideation.

Current Impairments (please circle one)

Key: 0=none, 1= mild or mildly incapacitating, 2= moderate or moderately incapacitating, 3= severe or severely incapacitating, n/a =not assessed for this impairment

Table with 6 columns: Impairment type, 0, 1, 2, 3, n/a. Rows: Mood Disturbances, Anxiety, Psychosis, Thinking/Cognition, Impulsive/Reckless, Activities of Daily Living, Medical/Physical Conditions, Job/School Performance, Social Relationships, Weight Change.

Substance Abuse/Dependence (Check all that apply)

- Alcohol, Illegal Drugs, Prescription Drugs

DSM-IV Multiaxial Diagnosis (please complete all five areas)

Axis I: _____

Axis II: _____

Axis III: Does the patient have a general medical condition that is potentially relevant to the understanding or management of the condition(s) noted on Axis I or II? Yes No

Axis IV: What is the severity of current psychosocial stressors? None Mild Moderate Severe

Axis V: GAF Score Highest Past Year: _____ Current: _____

Current Medications: (if not applicable, no response is required)

- Antipsychotic, Anti-anxiety, Hypnotic, Mood stabilizer, Anti-depressant, Psycho-stimulant, Other

Reason for Continued Treatment: (check all that apply)

- Remains symptomatic, Prepare for discharge, Maintenance, Facilitate return to work

Please Indicate Type(s) of Service You Are Requesting and the Frequency:

- Individual Therapy, Family Therapy, Group Therapy, Med Management, Med Management/Therapy, Evaluation, Wkly, Mnthly, BiWk, Other

- Are the member's family/supports involved in treatment? Coordination of care with other behavioral health providers? Coordination of care with medical providers? Has the member ever been evaluated by a psychiatrist?

For Substance Abuse/Dependence Requests ONLY:

- History of substance abuse treatment? Legal issues? Involvement in community support (AA/NA)?

Provider's Signature: _____

Date

For questions about completing this form call Quest @ 800-364-6352