

### Outpatient Substance Abuse Treatment Request Form

**Contact CBA via phone prior to a patient starting IOP/Partial treatment.**

Please complete the entire form to request group or individual therapy for substance abuse and fax back to CBA at (803) 714-6456. **Fax the request for Mental Health Counseling and subsequent updates using the outpatient treatment report form.**

Facility Name and Phone #: \_\_\_\_\_  
 Facility NPI #: \_\_\_\_\_

**For Initiating Certification:**

Patient's Name: \_\_\_\_\_ ID Card #: \_\_\_\_\_  
 Start Date for Treatment: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_  
 Clinician to See Patient: \_\_\_\_\_  
 Clinician NPI #: \_\_\_\_\_

**Address Where Services are Rendered:** \_\_\_\_\_

Diagnosis:	CPT Treatment Codes:
Axis I _____	90804 _____ sessions/week
Axis II _____	90806 _____ sessions/week
Axis III _____	90847 _____ sessions/week
Axis IV _____	90853 _____ sessions/week
Axis V _____	Other _____ sessions/week
Current GAF: _____	

Brief description of treatment plan, as well as goals: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What substance(s) is the patient currently using?

Substance(s)	Age at Onset	Frequency of Use	Amount Used	Duration of Current Episode	Last Use	UDS/BAL

Circle problems associated with use: School/Work    Family/Friends    Social/Recreational    Legal  
 Explain: \_\_\_\_\_  
 \_\_\_\_\_

Specify Medical Co-morbidity: \_\_\_\_\_  
 Specify Support System: \_\_\_\_\_

Prior Treatment:

Facility Name	Dates of Service	Substance Used	Inpt/Outpt	Duration of Sobriety

**Certification is not valid until certification # is received from CBA.**

**Office Use Only:**

# of Visits Approved: \_\_\_\_\_ Date Range: \_\_\_\_\_  
 Certification #: \_\_\_\_\_ Reviewer: \_\_\_\_\_ Ext: \_\_\_\_\_

**Please make additional copies of this form for your office use. Thank You.**