Carrier or Appropriate Recipient:

State of Maryland

Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

PATIENT INFORMATION ***PRACTITIONER INFORMATION***

PATIENT'S FIRST NAME | PATIENT'S DATE OF BIRTH | PRACTITIONER ID# or TAX ID | PHONE NUMBER

MEMBERSHIP NUMBER | PRACTITIONER NAME, ADDRESS & PHONE

AUTHORIZATION NUMBER (If Applicable)

Date Patient First Seen For This Episode Of Treatment

Have you communicated with the PCP/other relevant health care practitioners about treatment? ○ Yes ○ No

DSM-IV MULTIAXIAL DIAGNOSIS (PLEASE COMPLETE ALL FIVE AXES)

AXIS I Dx Code . Dx Code .

AXIS II Dx Code .

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

AXIS IV Severity of current psychosocial stressors

○ None ○ Mild ○ Moderate ○ Severe

AXIS V: GAF Score Highest Past Year At first Session Current

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

○ Anti-psychotic ○ Anti-anxiety ○ Anti-depressant ○ Psycho-stimulant ○ Injectables

○ Hypnotic ○ Non-psychotropic ○ Mood stabilizer/Anti-convulsant ○ Other

Symptoms

Please rate the patient's current status on these symptoms, if applicable. **If not applicable, no response is required.**

	Ideation	Plan	Prior Attempt	None		Present	Absent
Suicidal ideation	○	○	○	○	Self-injurious behavior	○	○
Homicidal ideation	○	○	○	○	Substance use problems	○	○

Authorization Request Details

CPT Code Number of Units

Frequency (once a week, etc.):_____

Requested Start Date of Authorization: _____/_____/_____

Complete this section only if a second CPT is needed.

CPT Code Number of Units

Frequency (once a week, etc.):_____

Requested Start Date of Authorization: _____/_____/_____

Signature of practitioner: _____ Date

My signature attests that I have a current valid license in the state to provide the requested services.