



Outpatient Treatment Registration Form Mental Health Services

Gateway Health Plan® 1-866-755-7299 Fax: 717-540-1146

Requests need to be submitted within 5 business days of requested service start date (4:00 p.m. fax cutoff)

Member Name: _____		Member SSN: _____	
Gateway Health Plan® Member ID#: _____		Member DOB: _____	
Member Address: _____		Member Phone: _____	
Provider Name (billing name): _____		Contact Person: _____	
Provider Address (billing address): _____		Provider ID: _____	
City, State, Zip: _____		Phone: _____ Fax: _____	

Initial Request
 Continued Service Request

DSM-IV MULTIAXIAL DIAGNOSIS - Please Complete

AXIS I /
AXIS IV None Mild Moderate Severe
AXIS II /
AXIS V GAF Highest Past Year _____ At 1st Session _____ Current _____
AXIS III _____

TREATMENT(S) REQUESTED: Check 1 or more below – Submit within 5 business days of requested start date

90801- Diagnostic Interview			Date	Name & Credentials of Professional Conducting Interview:			
Treatment Code	# of Sessions Used in Previous Auth. Period	Start Date	Requested Frequency	Total Used To Date	Description	Unit	# of Sessions Requested
90862					Pharmacologic Management <input type="checkbox"/> MD/DO <input type="checkbox"/> CRNP	(15 min.)	
90806					Individual Psychotherapy	(45-50 min.)	
90847					Family Psychotherapy with Mbr	(15 min.)	
90846					Family Psychotherapy without Mbr	(15 min.)	
90853					Group Psychotherapy, 2-10 person If specialized group, notate in comments	(30 min.)	
Other (Code)							
Other (Code)							

Comments/Name/degree of professional providing Tx: _____

<p>CBHNP USE ONLY: Authorization Number: _____</p> <p><input type="checkbox"/> Client not enrolled in Medicare Assured. Please check eligibility.</p> <p><input type="checkbox"/> Please check Identification information (SSN, DOB, Gateway Health Plan® ID, Name)</p> <p><input type="checkbox"/> Other: _____</p>
