State of Maryland
Uniform Treatment Plan Form
(For Purposes of Treatment Authorization)

Carrier or Appropriate Recipient:
Magellan Behavioral Health
Fax: 800-365-5030
- or -
PO Box 4930
Columbia, Maryland 21046-4930

PATIENT INFORMATION

PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH __ / __ / ____

MEMBERSHIP NUMBER

AUTHORIZATION NUMBER (If Applicable)

PRACTITIONER INFORMATION

PRACTITIONER ID# or TAX ID

PHONE NUMBER

PRACTITIONER NAME, ADDRESS & PHONE

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
Suicidal ideation	○	○	○	○
Homicidal ideation	○	○	○	○

	Present	Absent
Self-injurious behavior	○	○
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.