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Therapeutic behavioral on-site services for children and adolescents certification request

Date:

Submission of this form constitutes a request for certification of coverage for therapeutic behavioral on-site (TBOS) services for the member referenced below. All information is required for Amerigroup Community Care to complete the review of this request. A licensed mental health clinician must sign this form prior to coverage certification of TBOS services. Fax completed and signed referral forms to 1-800-505-1193, Attn: Behavioral health case management.

I. Member information

				Male: ☐	Female: ☐
Member name	Member ID (Medicaid or Amerigroup #)	Age	Date of birth	Sex	

	☐ SED ☐ EH ☐ ESE	☐		Dates:
Grade	Special education		Other-specify	Out-of-school suspensions within the last three months

II. Provider information

Agency	Referring clinician	Provider number
Telephone number	Fax number	Email

III. Clinical description

Provide specific details of behaviors and symptoms within the last three months to explain why TBOS services are needed to prevent a more restrictive behavioral health placement.

IV. Prior treatment

Describe any prior mental health outpatient treatment, duration and response to treatment focusing on any recent failure of outpatient treatment within the past three months. Please include dates and agencies.

List past inpatient psychiatric admissions, including agency, dates and reasons for admission.

Agency	Date	Reason for admissions

V. Support system

List family members, caretakers or legal guardians who will be participating in therapy.

List any current or past medical and/or surgical conditions. ☐ None

Date	Conditions/diagnosis

***Please note:** Automatically submit the past three months' psychiatric evaluation notes, past two months' outpatient treatment note and the most recent assessment (i.e., biopsychosocial history, in-take assessment and mental status assessment) with this certification.

VI. Clinical impression

	Code	Diagnosis
I		
II		
III		
IV		
V		

List all current medications, including psychiatric medications. Please include dose and frequency.

Medication	Dose	Frequency

VII. Requested units

The maximum number of requested units per Medicaid handbook cannot exceed 36 units (nine hours/month) for combined HO (therapy) and HM (behavioral management). HN units cannot exceed 128 units (32 hours/month). Approved units will not exceed six months.

HO units per month	HM units per month	HN units per month

TBOS units

4 units = 1 hr/month
16 units = 4 hr/month
20 units = 5 hr/month
24 units = 6 hr/month
28 units = 7 hr/month
30 units = 7.5 hr/month
32 units = 8 hr/month
34 units = 8.5 hr/month
36 units = 9 hr/month

VIII. Credentials

I hereby certify that as a licensed mental health clinician of the healing arts of behavioral health I have reviewed this certification for the Amerigroup member listed on page one and find that he or she meets the Medicaid community mental health handbook's criteria for TBOS services.

Licensed mental health clinician's signature and license number Date