State of Maryland

Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

Carrier or Appropriate Recipient:

PATIENT INFORMATION

PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH ___ / ___ / ____

MEMBERSHIP NUMBER

AUTHORIZATION NUMBER (If Applicable)

PRACTITIONER INFORMATION

PRACTITIONER ID# or TAX ID: 80-0192505

PHONE NUMBER: 4102350005

PRACTITIONER NAME, ADDRESS & PHONE

Jennifer Palmer, M.D.
3355 Keswick Road, Suite 100
Baltimore, MD 21211

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: 9080 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 requested services.