Aetna Better Health® of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223

AETNA BETTER HEALTH® OF KENTUCKY
Multisystemic Therapy (MST) Outpatient Treatment Request Form
Fax as a single document to AETNA BETTER HEALTH OF KENTUCKY **1-855-301-1564, for SKY 1-833-689-1424**

Rendering Provider name (please print)		**Provider phone:**	**Provider fax:**
Member name (please print)	**Age**	**Medicaid ID#**	**Date of birth** / /
Group Provider NPI: (required)		**ZIP**	**TAX ID**
Primary Diagnoses ICD-10 Code: SED? ☐ Yes ☐ No	**Co-morbid Medical Diagnoses ICD-10 Code:**	**Initial MST request** ☐	**Extension of MST request** ☐
Is the member currently involved with the Juvenile Justice System? ☐ Yes ☐ No		**Is the member returning from an out-of-home placement?** ☐ Yes ☐ No	

***For an extension of MST services, please attach the updated treatment plan reflecting current clinical condition and response to treatment.**
****Service components of MST shall not be duplicated by other providers while the client is receiving MST.**

Service Code	Units Requested
H2033	

Request start date:_______________End date:_______________
Please note: Requests must be received within (2) buisness days of the requested start date.

The maximum timeframe/units that may be requested for the initial MST request is (4) months/(300) units.
The maximim timeframe/units that may be requested for an extension of MST services is (2) months/(200) units.
If units are exhausted prior to the end date of the authorization, an extension request must be submitted.

Functional Impairment Rating Scale (Select the degree of impairment in the following functional areas.				
Functional Category	N/A	Mild	Moderate	Severe
Self-Care (inability to protect self, perform ADLs, self-injurious, reckless decision-making, failure to address health/safety needs)	☐	☐	☐	☐
Interpersonal Relationships (aggressive/violent interactions, lacks behavioral control, poor decision making/judgement, isolated/withdrawn, unable to form/maintain satisfactory relationships)	☐	☐	☐	☐
Family Life (inability to live in a family type environment, emotional/disruptive behaviors, violence and/or disregard for safety/welfare of those in the home, inability to conform to expectations)	☐	☐	☐	☐
School/Work (failing grades, truancy, expulsion, suspension, property damage, violence toward others. poor relationships with co-workers, hostile behavior on the job)	☐	☐	☐	☐
Self Direction (inability to control behavior/make age-appropriate decisions, violations of law/community norms, disruptive/inappropriate in community)	☐	☐	☐	☐

Presenting Problem Description: (Include behavioral health symptoms, evidence of severe emotional/behavioral disturbance, history of treatment**,** biopsychosocial information.)

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Juvenile Justice Involvement/Risk of Involvement: Describe the member's involvement in the juvenile justice system, or how the recipient is at serious risk of involvement with the juvenile justice system.

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Risk of Out-Of-Home Placement: Decribe how the member is at risk of out-of-home placement.

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Substance Use: If applicable, describe the recipient's current substance use/history of substance use behaviors, including patterns, frequency, substances used.

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If this is a request for extension of MST services, please provide the following additional information and update the above to reflect current status.

Describe what progress has been made during the initial MST service period.

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What goals treatment have not yet been achieved?

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Describe the specific plan and/or adjustments to the treatment plan that have been made to address lack of progress on treatment goals.

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Describe the family/caregiver involvement in treatment or what efforts are being made that are expected to lead to engagement.

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Provider Signature:____ **Date:**_________________