

## INSTRUCTIONS

### COMPLETING THE VALUEOPTIONS OUTPATIENT REVIEW FORM (ORF2)

**Please note:** To ensure timely processing of your Outpatient Review Form, please complete ALL sections prior to submission to ValueOptions. TYPE or PRINT LEGIBLY. Check/circle responses where applicable.

#### Member and Provider Demographics:

Information requested	How to complete this section
Member's ID #	This is usually the ID # from the member's benefit card. However for some plans it is still the policy holder's SSN or Alternate ID #.
Insured's Employer/Benefit Plan	This is either the policy holder's employer's name or the Health Plan the member belongs to, depending on who holds the contract with ValueOptions.
Is the member currently receiving disability benefits?	This could be for either Medical or Psychiatric reasons.
Provider Program/Clinic (if applicable)	If provider is billing through a facility/clinic rather than as an individual provider
ValueOptions Provider # (if known)	This is the Provider's ValueOptions ID number or GHI PIN# (if applicable)
Service Address	Address where services are rendered

#### Current Risk Assessment:

Information requested	How to complete this section
Member's risk to self:	Indicate member's level of, or absence of, suicidality by circling the appropriate value. <b>This must be completed</b>
Member's risk to others:	Indicate potential for, or absence of, violence and/or abuse by circling the appropriate value. <b>This must be completed</b>

#### Current Impairments: (please select/circle one value for each type of impairment – this must be completed)

Rating	Definition
0 = none	No evidence of impairment
1 = mild	Occasional impairment or difficulties, but no interference with normal daily activities
2 = Moderate	Currently experiencing difficulties, frequent disruption in daily activities, requires periodic or continuous assistance with some tasks
3 = Severe	Currently experiencing severe symptoms, potential risk of harm to self/others, severe distress and/or disruption in daily activities
na = not assessed	Impairment was not assessed – <b>Please note use of NA may result in additional phone calls with ValueOptions to ascertain this information.</b>

Information requested	How to complete this section
Diagnosis	All five Axes are required. List Primary; add Secondary as appropriate. Please see DSM IV-TR for further instructions.
Psychiatric Treatment in the Past 12 Months	This should <b>not</b> include the member's current course of outpatient treatment..
Substance Abuse Treatment in the Past 12 Months	This should <b>not</b> include the member's current course of outpatient treatment.
Treatment Compliance (Non-Med)	This is compliance with outpatient behavioral health treatment, not medication compliance
Please indicate type(s) of service provided BY YOU, and the frequency	This should only include treatment that you are providing to the member.
Please indicate type(s) of service provided and frequency	If you are checking the "Other" Box please indicate the specific CPT codes and/or frequency you are requesting
Please indicate type(s) of service provided BY OTHERS	This should only include treatment the member might be receiving from other providers. Please check all that apply.
Are the Member's family/supports involved in treatment?	This must be completed
Coordination of care with other behavioral health providers?	This must be completed

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Coordination of care with medical providers?	This must be completed
Current Psychotropic Medications	List the member's primary medications, the dosage, frequency and whether or not the patient is usually adherent. If more space is needed please list on a separate sheet of paper.