



Mental Health Outpatient Treatment Report Form

Please submit via the provider website at <https://mediproviders.anthem.com/ca> or fax to **1-866-877-5229**.

Fill out completely to avoid delays.

Identifying data (Please include patient name on all relevant pages in designated field.)		
Patient's name:		
Medicaid ID:	DOB:	
Patient's address:		
City and state:	ZIP code:	
Provider information		
Provider name:		
Tax ID:	Phone:	Fax:
PCP name:		PCP NPI:
Name of other behavioral health providers:		
ICD-10 diagnoses		
Medications		
Current medications: Indicate changes since last report.	Dosage	Frequency

Current risk factors:

- Suicide: None Ideation Intent without means Intent with means
 Contracted not to harm self
- Homicide: None Ideation Intent without means Intent with means
 Contracted not to harm others
- Physical or sexual abuse or child/elder neglect: Yes No
 - If **yes**, patient is: Victim Perpetrator Both Neither (but abuse exists in family)
 - Abuse or neglect involves a child or elder: Yes No
 - Abuse has been legally reported: Yes No

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Anthem Blue Cross Cal MediConnect Plan is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Blue Cross of California Partnership Plan, Inc. are independent licensees of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Patient name:

Symptoms that are the focus of current treatment
Progress since last review
Functional impairments/strengths (including interpersonal relations, personal hygiene and work/school)
Recovery environment — Describe level of stress (including support system).
Engagement/level of active participation in treatment
Housing
Co-occurring medical/physical illness
Family history of mental illness or substance abuse

Patient name: _____

For substance use disorders, please complete the following additional information.

Current assessment of American Society of Addiction Medicine (ASAM) criteria	
Dimension (describe or give symptoms)	Risk rating
Dimension 1 (acute intoxication and/or withdrawal potential — include vitals and withdrawal symptoms): _____ _____	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/> Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 2 (biomedical conditions and complications): _____ _____	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/> Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 3 (emotional, behavioral or cognitive complications): _____ _____	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/> Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 4 (readiness to change): _____ _____ _____ _____	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/> Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 5 (relapse, continued use or continued problem potential): _____ _____ _____	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/> Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 6 (recovery living environment): _____ _____ _____	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/> Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>

Patient name: _____

If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?

List patient's treatment history (including all levels of care).

Level of care	# of distinct episodes/sessions	Date of last episode/session	Level of care	# of distinct episodes/sessions	Date of last episode/session
Outpatient psychology			Inpatient psychology		
Outpatient substance abuse			Inpatient substance abuse		
CD residential treatment program			PMIC		

Requested service authorization

Procedure code:	# of units:	Frequency:	Requested start date:	Estimated # units to complete treatment:
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Treatment goals for each type of service (specify) with expected dates to achieve them

1. _____
2. _____
3. _____
4. _____
5. _____

Objective outcome criteria by which goal achievement is measured

1. _____
2. _____
3. _____
4. _____
5. _____

Patient name: _____

Discharge plan and estimated discharge date

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Expected outcome and prognosis:

- Return to normal functioning.
- Expect improvement/anticipate less than normal functioning.
- Relieve acute symptoms/return to baseline functioning.
- Maintain current status/prevent deterioration.

Please attach summary sheets of any applicable assessments.

Psychological/neuropsychological testing requests require a separate form.

Treatment plan coordination

I have requested permission from the member/member's parent or guardian to release information to the PCP/psychiatrist: <input type="checkbox"/> Yes <input type="checkbox"/> No If no , rationale why this is inappropriate: _____ Treatment plan was discussed and agreed upon by the member/member's parent or guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Provider's signature: _____

Date: _____