



## Mental Health Outpatient Treatment Report Form

Telephone: 1-844-396-2330

Fax: 1-800-505-1193

Identifying data		
Patient name:		
Medicaid ID:	Date of birth:	
Address:		
City, state:	ZIP code:	
Provider information		
Provider name:		
Tax ID:	Phone:	Fax:
PCP name:	PCP NPI:	
Name of other behavioral health providers:		
DSM-V diagnoses		
Medications		
Current medications (indicate changes since last report):	Dosage:	Frequency:
Current risk factors		
Suicide:		
<input type="checkbox"/> None <input type="checkbox"/> Ideation <input type="checkbox"/> Intent without means <input type="checkbox"/> Intent with means <input type="checkbox"/> Contracted not to harm others		
Homicide:		
<input type="checkbox"/> None <input type="checkbox"/> Ideation <input type="checkbox"/> Intent without means <input type="checkbox"/> Intent with means <input type="checkbox"/> Contracted not to harm others		

<https://mediproviders.anthem.com/nv>

Physical or sexual abuse or child/elder neglect: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, patient is:	<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> Neither, but abuse exists in family
Abuse or neglect involves a child or elder:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abuse has been legally reported:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Symptoms that are the focus of current treatment</b>	
<b>Progress since last review</b>	
<b>Functional impairments or supports</b>	
Family/interpersonal relationships:	
<b>Job/school</b>	
<b>Housing</b>	
<b>Co-occurring medical/physical illness</b>	
<b>Family history of mental illness or substance abuse</b>	

**Patient's treatment history, including all levels of care**

Level of care	Number of distinct episodes/sessions	Date of last episode/session	Level of care	Number of distinct episodes/sessions	Date of last episode/session
Outpatient psych			Inpatient psych		
Outpatient substance abuse			Inpatient substance abuse		
IOP			RTC psych		
PHP			RTC substance abuse		

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. _____
Discharge plan and estimated discharge date
1. _____
2. _____
3. _____
4. _____
5. _____

**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

Requested service authorization				
Procedure code:	Number of units:	Frequency:	Requested start date:	Estimated number of units to complete treatment:
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**Note: Psychological/neuropsychological testing requests require a separate form.**

Treatment plan coordination
<p>I have requested permission from the patient/patient's parent or guardian to release information to the PCP.</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No      If no, give rationale: _____</p> <p>Treatment plan was discussed with and agreed upon by the patient/patient's parent or guardian.</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No      If no, give rationale: _____</p>

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

Disclaimer: Authorization indicates that Anthem Blue Cross and Blue Shield Healthcare Solutions determined medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.