Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

Mental health outpatient treatment report form

Phone: **1-800-901-0020**; Fax: **1-800-505-1193**

Fill out completely to avoid delays.

Identifying data:		
Patient's name:		
Medicaid ID:		DOB:
Patient's address:		
City, State, ZIP Code:		
Provider information:		
Provider name:		
Tax ID:	Phone:	Fax:
PCP name:		PCP NPI:
Name of other behavioral health providers:		
DSM-[IV] TR diagnosis:		
AXIS I:	AXIS II:	AXIS III:
AXIS IV:	AXIS V current:	Highest in past year:

https://mediproviders.anthem.com/va

AVAPEC-1196-16 June 2016

Patient name: _____

Current clinical information:

Symptoms/problems	Mild	Moderate	Severe	Acute	Chronic
Anxiety disorders					
Obsessions/ compulsions					
Generalized anxiety					
Panic attacks					
Phobias					
Somatic complaints					
PTSD symptoms					
Depression					
Impaired concentration					
Impaired memory					
Psychomotor retardation					
Sexual issues					
Appetite disturbance					
Irritability					
Agitation					
Sleep disturbance					
Hopelessness/ helplessness					
Mania					
Insomnia					
Grandiosity					
Pressured speech					
Racing thoughts/ flight of ideas					
Poor judgment/ impulsiveness					

Symptoms/problems	Mild	Moderate	Severe	Acute	Chronic
Psychotic disorders					
Delusions/paranoia					
Self-care issues					
Hallucinations					
Disorganized thought process					
Loose associations					
Substance abuse					
Loss of control of dosage					
Amnesic episodes					
Legal problems					
Alcohol abuse					
Opiate abuse					
Prescription medication abuse					
Polysubstance abuse					
Personality disorder					
Oddness/eccentricities					
Oppositional					
Disregard for law					
Recurring self-injuries					
Sense of entitlement					
Passive aggressive					
Dependency					
Enduring traits of:					

Patient name: _____

Medications (optional for nonphysicians):		
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

Symptoms that are the focus of current treatment:

_____
_____
_____

Progress since last review:

_____
_____
_____

Functional impairments or supports:

Family/interpersonal relationships:

_____
_____
_____

Patient name: _____

Job/school:

_____
_____
_____

Housing:

_____
_____
_____

Co-occurring medical/physical illness:

_____
_____
_____
_____
_____
_____

Family history of mental illness:

_____
_____
_____
_____

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

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

Patient name: _____

Treatment goals:

1. _____
2. _____
3. _____

Objective outcome criteria by which goal achievement is measured:

1. _____
2. _____
3. _____

Discharge plan and estimated discharge date:

_____

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

Patient name: _____

Risk history:
Explain any significant history of suicidal, homicidal, impulse control or any behavior that may impact the patient's level of functioning: _____ _____ _____ _____ _____ _____ _____ _____

Requested authorization:			
Procedure code:	Number of units:	Frequency:	Units approved:
Procedure code:	Number of units:	Frequency:	Units approved:
Procedure code:	Number of units:	Frequency:	Units approved:
Procedure code:	Number of units:	Frequency:	Units approved:
Procedure code:	Number of units:	Frequency:	Units approved:

Provider's signature: _____

Date: _____

Disclaimer: Authorization indicates that HealthKeepers, Inc. 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.