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Mental Health Outpatient Treatment Report Form

Please submit via the provider website at https://providers.amerigroup.com/DC or fax to 1-800-505-1193.

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

Symptoms that are the focus of current treatment

Patient name: _____

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

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: ☐ Mild: ☐ Moderate: ☐ Significant: ☐ Severe: ☐
Dimension 2 (biomedical conditions and complications): _____ _____	Minimal/none: ☐ Mild: ☐ Moderate: ☐ Significant: ☐ Severe: ☐
Dimension 3 (emotional, behavioral or cognitive complications): _____ _____	Minimal/none: ☐ Mild: ☐ Moderate: ☐ Significant: ☐ Severe: ☐

Patient name: _____

Current assessment of ASAM criteria	
Dimension (describe or give symptoms)	**Risk rating**
Dimension 4 (readiness to change): _____ _____ _____ _____ _____	Minimal/none: ☐ Mild: ☐ Moderate: ☐ Significant: ☐ Severe: ☐
Dimension 5 (relapse, continued use or continued problem potential): _____ _____ _____ _____	Minimal/none: ☐ Mild: ☐ Moderate: ☐ Significant: ☐ Severe: ☐
Dimension 6 (recovery living environment): _____ _____ _____ _____	Minimal/none: ☐ Mild: ☐ Moderate: ☐ Significant: ☐ Severe: ☐
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		

Patient name: _____

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. _____

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.

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: ☐ **Yes** ☐ **No**
If **no**, rationale why this is inappropriate:_____
Treatment plan was discussed and agreed upon by the member/member's parent or guardian: ☐ **Yes** ☐ **No**

Provider's signature: _____ Date: _____