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Mental Health Outpatient Treatment Report Form

TELEPHONE: 1-800-454-3730 FAX: 1-800-505-1193

FILL OUT COMPLETELY TO AVOID DELAYS

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: ☐ 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

Patient name: _____

PATIENT'S TREATMENT HISTORY, INCLUDING ALL LEVELS OF CARE

SYMPTOMS THAT ARE THE FOCUS OF CURRENT TREATMENT
PROGRESS SINCE LAST REVIEW
FUNCTIONAL IMPAIRMENTS OR SUPPORTS
Family/interpersonal relationships:
JOB/SCHOOL
HOUSING
CO-OCCURRING MEDICAL/PHYSICAL ILLNESS
FAMILY HISTORY OF MENTAL ILLNESS OR SUBSTANCE ABUSE

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. _____

Patient name: _____

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

I have requested permission from the patient/patient's parent or guardian to release information to the PCP.

☐ Yes ☐ No If no, give rationale:_____

Treatment plan was discussed with and agreed upon by the patient/patient's parent or guardian.

☐ Yes ☐ No If no, give rationale:_____

Provider signature: _____ Date: _____

Disclaimer: Authorization indicates that Amerigroup Community Care 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.