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Mental Health Outpatient Treatment Report form

Please submit via website at https://providers.amerigroup.com/ia or fax to 1-866-877-5229.

Fill out completely to avoid delays.

Identifying data		
Patient's name:		
Medicaid ID:		Date of birth:
Patient's address:		
City, state:		ZIP code:
Provider information		
Requesting provider name:		
Tax ID:	Phone:	Fax:
PCP name:		PCP NPI:
Name of Integrated Health Home (IHH) completing assessments:		
IHH care coordinator completing assessment: name and contact information		
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
Hallucinations: ❑ Auditory ❑ Visual ❑ Both ❑ None
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

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

Patient name: ____

Please complete all boxes that are applicable for this member or attach additional clinical information:

Symptoms that are the focus of current treatment
Progress since last review
Functional impairments/strengths (including interpersonal relations, personal hygiene, work/school)
Recovery environment (describe, including support system, level of stress)
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, 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: ☐
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: ☐

Patient name: ____________________

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

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		
Chemical dependency residential treatment program				Psychiatric Medical Institute for Children		
Other:						

Current authorizations being requested:

Requested service authorization				
Procedure code:	Number of units:	Frequency:	Requested start date:	Estimated # units to complete treatment:
Rendering provider if different than requesting (including tax ID #):				
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Patient name: ____

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 with and agreed upon by the member/member's parent or guardian.   ☐ Yes ☐ No

Provider's signature: ________________________________ Date: _________________________________