



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

Eligibility status:

Children's mental health waiver: None Active New Renewal (if a renewal, please attach previous Notice of Decision [NOD])

Habilitation state plan home- and community-based services: None Active New Renewal (if a renewal, please attach previous NOD)

Dates of NOD for services: _____ to _____

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: Audio Visual Both Neither
- 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: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/>
	Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 2 (biomedical conditions and complications): _____ _____	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/>
	Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 3 (emotional, behavioral or cognitive complications): _____ _____	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/>
	Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 4 (readiness to change): _____ _____	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/>
	Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 5 (relapse, continued use or continued problem potential): _____ _____	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/>
	Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
Dimension 6 (recovery living environment): _____ _____	Minimal/none: <input type="checkbox"/> Mild: <input type="checkbox"/> Moderate: <input type="checkbox"/>
	Significant: <input type="checkbox"/> Severe: <input type="checkbox"/>
If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?	

Patient name: _____

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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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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

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: _____