Outpatient Treatment Report FORM C
Amerigroup Community Care
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FILL OUT COMPLETELY TO AVOID DELAYS

IDENTIFYING DATA

Patient's Name:_____ Medicaid #: _____ DOB: _____
Patient's Address:_____ State:_____ ZIP:_____

PROVIDER INFORMATION

Provider Name:_____Tax ID #:_____
Phone #:_____ Fax #: _____
PCP Name:_____ Name of Other Behavioral Health Provider(s):_____
PCP NPI:_____

DSM-IV TR DIAGNOSIS

Axis I:_____ Axis II: _____ Axis III: _____
Avis IV:_____ Avis V Current:_____ Highest in Past Year:_____

CURRENT CLINICAL INFORMATION

Symptoms/Problems	Mild	Moderate	Severe	Acute	Chronic			Mild	Moderate	Severe	Acute	Chronic
Anxiety disorders							**Psychotic disorders**					
▪ Obsessions/compulsions							▪ Delusions/paranoia					
▪ Generalized anxiety							▪ Self-care issues					
▪ Panic attacks							▪ Hallucinations					
▪ Phobias							▪ Disorganized thought process					
▪ Somatic complaints							▪ Loose associations					
▪ PTSD symptoms							**Substance abuse**					
Depression							▪ Loss of control of dosage					
▪ Impaired concentration							▪ Amnesic episodes					
▪ Impaired memory							▪ Legal problems					
▪ Psychomotor retardation							▪ Alcohol abuse					
▪ Sexual issues							▪ Opiate abuse					
▪ Appetite disturbance							▪ Prescription medication abuse					
▪ Irritability							▪ Polysubstance abuse					
▪ Agitation							**Personality Disorder**					
▪ Sleep disturbance							▪ Oddness/eccentricities					
▪ Hopelessness/Helplessness							▪ Oppositional					
Mania							▪ Disregard for law					
▪ Insomnia							▪ Recurring self-injuries					
▪ Grandiosity							▪ Sense of entitlement					
▪ Pressured speech							▪ Passive aggressive					
▪ Racing thoughts/flight of ideas							▪ Dependency					
▪ Poor judgment/impulsiveness							▪ 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: _____

JOB/SCHOOL: _____

HOUSING: _____

CO-OCCURRING MEDICAL/PHYSICAL ILLNESSES: _____

FAMILY HISTORY OF MENTAL ILLNESS: _____

Patient Name:_____

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				PHP		
Outpatient – substance abuse				Inpatient – psych RTC		
IOP				Inpatient – substance abuse		

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

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

_____

_____

REQUESTED AUTHORIZATION:

Procedure Code:_____	Number of Visits:_____	Frequency:_____	Units Approved:_____
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Procedure Code:_____	Number of Visits:_____	Frequency:_____	Units Approved:_____
☐ Approved – Auth #:			

Provider's Signature: _____ Date: _____

Disclaimer: Authorization indicates that Amerigroup determined that medical necessity has been met fort eh requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.