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Behavioral Health Outpatient Treatment Form

Please submit this form to Amerigroup Washington, Inc. using our preferred method via https://providers.amerigroup.com/WA. This can also be submitted via fax to 1-844-887-6357.

Identifying data		
Patient name:		
Medicaid ID:	Date of birth:	
Address:		
City, state:	ZIP code:	
Provider information		
Provider name:		
TIN:	Phone:	Fax:
PCP name:	PCP NPI:	
Names 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	
Symptoms that are the focus of current treatment		
Progress since last review		
Functional impairments or supports		
Family/interpersonal relationships:		

Work/school
Housing
Co-occurring medical/physical illness
Family history of mental illness or substance abuse

Patient's treatment history, including all levels of care					
Level of care	**Number of distinct episodes/ sessions**	**Number of distinct episodes/ sessions**	**Level of care**	**Number of distinct episodes/ sessions**	**Number of distinct episodes/ sessions**
Outpatient psych			Inpatient psych		
Outpatient substance abuse			Inpatient substance abuse		
Intensive outpatient treatment			Residential treatment center psych		
Partial hospitalization program			Residential treatment center substance abuse		

Treatment goals for each type of service (Specify with expected dates to achieve the goal.)
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
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 not, provide rationale:
Treatment plan was discussed with and agreed upon by the patient/patient's parent or guardian. ☐ Yes ☐ No If not, provide rationale:

Provider signature: _____ **Date:** _____