Mental Health Outpatient Treatment Report Form

Please submit this form electronically using our preferred method at https://www.availity.com. This can also be submitted via fax to 1-844-430-1703.

Identifying data					
Patient name					
Member ID		DOB			
Address					
City, state		ZIP code			
Provider information					
Provider name					
Tax ID		Phone		Fax	
PCP name		PCP NPI			
Names of other behavioral health providers					
ICD-10 diagnoses (behavioral and physical health)					

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

* Availity is an independent company providing administrative services on behalf of Amerigroup.

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

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		
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.

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

Provider signature:_____ Date:_____

Protected Health Information (PHI)
These documents contain PHI. Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call us at 1-866-805-4589.

Providers: You are required to return, destroy or further protect any PHI you receive pertaining to patients that you are not currently treating. You are required to immediately destroy any such PHI, or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

☐ By checking this box, I hereby certify that the protected health information (PHI) contained in the correspondence received in error has been destroyed and has not otherwise been retained, utilized, or further disclosed. In the event the PHI must be retained it will further be protected until the time it can be destroyed.