Amerigroup
District of Columbia

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Mental Health Outpatient Treatment Report Form

Please submit this form electronically using our preferred method by logging onto Availity from the Amerigroup District of Columbia, Inc. provider website at https://providers.amerigroup.com/DC. This form can also be submitted via fax to 1-800-505-1193 on the last authorized day.

Fill out this form completely to avoid delays.

Identifying data	
Patient name:	
Medicaid ID:	Patient DOB:
Patient address, city, state, ZIP:	
Provider information	
Provider name:	
Tax ID:	Phone and fax:
PCP name:	PCP NPI:
Name of other behavioral health providers:	

ICD-10-CM 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
Symptoms that are the focus of current treatment
Progress since last review
Functional impairments or strengths — Including interpersonal relations, personal hygiene, and work or school.
Recovery environment — Describe level of stress (including support system).
Engagement/level of active participation in treatment
Housing
Co-occurring medical/physical illness

Family history of mental illness or substance use

Current assessment of American Society of Addiction Medicine (ASAM) For substance use disorders, please complete the following additional information.	
Dimension **(describe or give symptoms)**	**Risk rating**
Dimension 1 (acute intoxication or withdrawal potential — include vitals and 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
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**	**Number of distinct episodes/ sessions**	**Level of care**	**Number of distinct episodes/ sessions**	**Number of distinct episodes/ sessions**
Outpatient psychology			Inpatient psychology		
Outpatient substance use			Inpatient substance use		
CD residential treatment program			PMIC		

Requested service authorization				
Procedure code:	Number of units:	Frequency:	Requested start date:	Estimated number of units to complete treatment:
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Treatment goals for each type of service (Specify with expected dates to achieve them.)

1.

2.

3.

4.

5.

6.

Objective outcome criteria by which goal achievement is measured
1. **2.** **3.** **4.** **5.** **6.**
Discharge plan and estimated discharge date
1. **2.** **3.** **4.** **5.** **6.**
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. **Note:** Psychological/neuropsychological testing requests require a separate form.
Treatment plan coordination
I have requested permission from the patient or patient's parent or guardian to release information to the PCP or psychiatrist: ☐ Yes ☐ No If **no**, rationale why this is inappropriate:____ Treatment plan was discussed and agreed upon by the patient or patient's parent or guardian: ☐Yes ☐ No
Provider signature:
Date:
Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not 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.