Outpatient treatment form

For Amerigroup STAR+PLUS Medicare-Medicaid Plan (MMP) program

Amerigroup RealSolutions in healthcare

STAR+PLUS PROGRAM — Your Health Plan ■ Your Choice

INSTRUCTIONS: Please print all information. Fax completed form to 1-800-505-1193

PATIENT

Name _____ ID # _____ DOB _____ **REFERENCE #** _____

PROVIDER *Individual and/or Group*

Name _____ Tax ID _____ License # _____ Phone _____

Address _____ City _____ State _____ ZIP _____ Fax _____

DSM-IV or ICD-9 DIAGNOSIS *numeric + description*

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

current *highest past year*

MEDICAL CONDITIONS

- ☐ None
- ☐ Asthma/COPD
- ☐ Cancer
- ☐ Cardiovascular problems
- ☐ Other _____
- ☐ Chronic pain
- ☐ Dementia
- ☐ Diabetes
- ☐ Obesity

CURRENT RISK ASSESSMENT

☐ Suicidal	☐ Ideation	☐ Plan	☐ Intent	☐ Hx of harming self	☐ N/A
☐ Homicidal	☐ Ideation	☐ Plan	☐ Intent	☐ Hx of harming others	☐ N/A

MEDICATIONS

Medication	Psychotropic	Medical	Prescribing MD	PCP	Psychiatrist	Other
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐

If affective or psychotic disorder is present and no medications are prescribed, please explain: _____

COORDINATION OF CARE

I have communicated with patient's

☐ PCP ☐ Specialist ☐ Psychiatrist ☐ Therapist

TREATMENT HISTORY

☐ Inpatient:	☐ Within past yr	☐ 1 to 3 yrs ago	☐ More than 3 yrs ago
☐ Outpatient:	☐ Within past yr	☐ 1 to 3 yrs ago	☐ More than 3 yrs ago

SYMPTOMS and FUNCTIONAL IMPAIRMENT *If present, check degree (✓)*

On Disability ☐ Yes ☐ No

	Mild	Mod.	Severe		Mild	Mod.	Severe		Mild	Mod.	Severe
Anxiety	☐	☐	☐	Hopelessness	☐	☐	☐	Obsessions/Compulsions	☐	☐	☐
Decreased energy	☐	☐	☐	ADLs	☐	☐	☐	Significant weight change	☐	☐	☐
Delusions	☐	☐	☐	Family/Relationships	☐	☐	☐	Panic attacks	☐	☐	☐
Depressed mood	☐	☐	☐	Inattention	☐	☐	☐	Sleep disturbance	☐	☐	☐
Hallucinations	☐	☐	☐	Irritability/Mood instability	☐	☐	☐	Physical health	☐	☐	☐
Hyperactivity	☐	☐	☐	Impulsivity	☐	☐	☐	Work/School	☐	☐	☐
Substance abuse/Dependence	☐	☐	☐	☐ Active ☐ In Remission							

If substance abuse is current or focus of treatment, complete the information below:

Substance of choice	Amount	Frequency	Date of last use
☐ Alcohol			
☐ Marijuana			
☐ Heroin			
☐ Opioids _____ *list*			
☐ Cocaine			
☐ Methamphetamine			
☐ Prescrip. drugs _____ *list*			
☐ Inhalants			

Is patient currently participating in a community-based support group? (Includes AA, NA, etc.) ☐ Yes ☐ No

If Yes, frequency of attendance: _____

Is there a sponsor? ☐ Yes ☐ No

DESIRED OBSERVABLE OUTCOMES

Patient agrees with treatment goals ☐ Yes ☐ No

_____

_____

PROVIDER'S CONTINUED TREATMENT PLAN

Modality and CPT code	Frequency	Anticipated Completion
☐ Individual 90804	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Ind. w/Med. Mgmt 90805	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Individual 90806	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Ind. w/ Med. Mgmt. 90807	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Couple/Family 90847	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Group 90853	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Medication Mgmt 90862	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Other _____	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)

TREATMENT PROGRESS

Level of improvement to date ☐ Minor ☐ Moderate ☐ Major

☐ No progress to date ☐ Maintenance tx of chronic condition

# of sessions provided to date _____

Start date for new authorization _____

Case Management referral? ☐ Yes ☐ No

My signature confirms that I am providing the requested services.

_____ _____

PROVIDER'S SIGNATURE ***DATE***

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees. PF-TX-0078-15 1163131