Anthem

Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect and Medicare Advantage

Mental Health Outpatient Treatment Report Form

This communication applies to the Medicaid and Medicare Advantage programs for Anthem Blue Cross and Blue Shield (Anthem).

Please submit form electronically using our preferred method at **https://availity.com**.* If you prefer to fax, you may send it to:

- Medicaid: **844-456-2698**
- Medicare Advantage: **844-430-1703**

Identifying data					
Patient name:					
Medicaid ID:			Date of birth:		
Address:					
City, State:			ZIP code:		
Provider information					
Provider name:					
Tax ID:		Phone:		Fax:	
PMP name:			PMP NPI:		
Names of other behavioral health providers:					
***DSM-5* diagnoses**					
Medications					
Current medications (indicate changes since last report)			Dosage		Frequency

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

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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/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

Jobs/school

Housing

Co-occurring medical/physical illness

Family history of mental illness or substance use

Patients treatment history, including all levels of care

Level of care	Number of distinct episodes/sessions	Date of last episode/session
Outpatient psych		
Outpatient substance use		
Intensive outpatient treatment		
Partial hospitalization		
Inpatient psych		
Inpatient substance use		
Residential treatment centers (RTC) (psychiatric)		
RTC (substance use)		

Treatment goals for each 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

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 PMP. ☐ Yes ☐ No

If no, give rationale:

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

☐ Yes ☐ No

If no, give rationale:

Provider signature:		Date:	

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