Anthem Blue Cross and Blue Shield Medicaid

Behavioral Health Service Report Form

Please print clearly — incomplete or illegible forms will delay processing.

Fax completed forms to: **888-881-6283**

Member information			
Patient name:		Health plan:	
Date of birth:		Medicaid RID #	
Last authorization #:		Impact plus member?	☐Yes ☐No
Provider information			
Provider name:			
Provider credential:	☐MD ☐PHD ☐Other (please list)		
Group/agency name:			
Physical address:			
Telephone number:		Facsimile number:	
Medicaid/TPI/NPI #:		Tax ID #:	
To whom authorization should be made:	Individual provider ☐Yes ☐ No	Group/facility ☐Yes ☐No	
Treatment			
Previous BH/SA treatment:	**NT:** ☐None -or- ☐Outpatient ☐Mental health ☐Substance abuse and/or ☐Inpatient ☐Mental health ☐Substance abuse List names / dates including hospitalizations if applicable:		
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Substance use			
Substance use:	☐None ☐By history and/or ☐Current/active		
Tobacco abuse:	☐None ☐By history and/or ☐Current/active		

https://providers.anthem.com/ky

KYBCBS-CD-023560 August 2023

Substance(s) used, amount, frequency, and last used:	
Symptoms/goals	

Current symptoms:		Severity (mark one): ☐Mild ☐Moderate ☐Severe
Progress since last treatment plan:		
Treatment goals (list primary complaint/problem to be addressed):		
List measurable treatment goals/skills/activities/objectives:		
Discharge goals: Objectively describe how you will know the patient is ready to discontinue treatment.		

Diagnosis:

Current risk/lethality:

	None	Low	Medium	High	Extreme
Suicidal*	☐	☐	☐	☐	☐
Homicidal*	☐	☐	☐	☐	☐
Assault/ violent behavior	☐	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐	☐

Current risk/lethality *2 to 5, progress/adherence *1 to 2 checked, give intervention.

*If **Yes** to suicidal/homicidal questions above, was a *Safety Contract* established?

☐Yes ☐No

If the member has a substance use and/or HIV diagnosis, has consent to release information for these conditions been obtained?

☐Yes ☐No ☐N/A

Primary medical physician (PCP) communication:
Has information been shared with the PCP regarding:

- Initial evaluation and treatment plan?
  ☐Yes ☐No
- Updated evaluation &treatment plan?
  ☐Yes ☐No

PCP name/date last notified:

If **No**, please explain:

<table>
<tr><td>Medications (note difficulty with adherence):</td><td colspan="5">*Adherence to treatment:

☐1 ☐2 ☐3 ☐4 ☐5
One Min Mod Max Met

Medical psychiatric evaluation done (even if PCP provided medication)?
☐Yes ☐No

Medication given by: ☐Psychiatrist ☐PCP ☐N/A</td></tr>
<tr><td colspan="6">Requested services authorization:

Services requested:
☐Individual ☐Group ☐Med management ☐ECT (Call medical management) ☐Psychosocial rehabilitation</td></tr>
<tr><td>Total sessions requested:</td><td></td><td>Frequency of visits:</td><td></td><td>CPT® /HCPS codes:</td><td></td></tr>
<tr><td colspan="2">Estimated # of sessions to complete treatment episode:</td><td></td><td>Requested state date:</td><td colspan="2"></td></tr>
<tr><td colspan="2">Provider signature/date:</td><td colspan="4"></td></tr>
<tr><td colspan="2">Notes:
* Psychological/neuropsychological testing requires a separate form.</td><td colspan="4"></td></tr>
</table>