Anthem

Medicaid Managed Care
Medicare Advantage

Mental Health Outpatient Treatment Report Form

This communication applies to Medicaid under Anthem Blue Cross and Blue Shield Healthcare Solutions and Medicare Advantage under Anthem Blue Cross and Blue Shield (Anthem).

Telephone: **1-844-396-2330**

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

- Medicaid: **1-844-430-6807**
- Medicare Advantage: **1-844-430-1703**

Identifying data		
Patient name:		Date of birth:
Medicaid ID:		
Address:		
Provider information		
Provider name:		
Tax ID:	Phone:	Fax:
PCP name:		PCP NPI:
Name of other behavioral health providers:		
DSM-V diagnoses		

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, LLC is an independent company providing administrative support services on behalf of Anthem.

Symptoms that are the focus of current treatment
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 use

Patient's treatment history, including all levels of care

Level of care	Number of distinct episodes/sessions	Date of last episode/session
Outpatient psych		
Inpatient psych		
Outpatient substance use		
Inpatient substance use		
IOP		
RTC psych		
PHP		
RTC substance use		

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:
Procedure code:	Number of units:	Frequency:	Requested start date:	Estimated number of units to complete treatment:
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 PCP. ☐ 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 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.