Anthem

BadgerCare Plus
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.

Please submit using our preferred method at **https://www.availity.com**.* If you prefer to fax, submit to the following:

- BadgerCare Plus: **1-844-456-2697**
- Medicare Advantage: **1-844-430-1703**

Identifying data		
Patient name:		
Medicaid ID:		DOB:
Address:		
City, State:		ZIP code:
Provider information		
Provider name:		
TIN:	Phone:	Fax:
PCP name:		PCP NPI:
Name 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 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 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		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

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 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.

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.