



## Mental Health Outpatient Treatment Report Form

Please note, this form applies to Healthy Blue + Medicare<sup>SM</sup> (HMO D-SNP) offered by Blue Cross and Blue Shield of North Carolina. Please submit this form electronically using our preferred method at <https://www.availity.com>. This can also be submitted via fax to **1-844-430-1703**.

Identifying Data				
Patient name				
Member ID		DOB		
Address				
City, state		ZIP code		
Provider Information				
Provider name				
Tax ID		Phone	Fax	
PCP name		PCP NPI		
Names of other behavioral health providers				
ICD-10 Diagnoses (Behavioral and Physical Health)				
Medications				
Current medications (indicate changes since last report):		Dosage:	Frequency:	
Current Risk Factors				
Suicide:				
<input type="checkbox"/> None <input type="checkbox"/> Ideation <input type="checkbox"/> Intent without means <input type="checkbox"/> Intent with means <input type="checkbox"/> Contracted not to harm self				
Homicide:				
<input type="checkbox"/> None <input type="checkbox"/> Ideation <input type="checkbox"/> Intent without means <input type="checkbox"/> Intent with means <input type="checkbox"/> Contracted not to harm others				
Physical or sexual abuse or child/elder neglect: <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, patient is		<input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> Neither, but abuse exists in family		

Note: Availity is an independent company providing administrative services for Healthy Blue + Medicare providers on behalf of Blue Cross and Blue Shield of North Carolina.

<https://www.bluecrossnc.com/provider-home>

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Abuse or neglect involves a child or elder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abuse has been legally reported	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Progress Since Last Review**

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**Functional Impairments or Supports**

Family/interpersonal relationships:

**Job/School**

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**Housing**

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**Co-occurring Medical/Physical Illness**

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**Family History of Mental Illness or Substance Abuse**

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Patient's treatment history, including all levels of care

Level of Care	Number of Distinct Episodes/Sessions	Number of Distinct Episodes/Sessions	Level of Care	Number of Distinct Episodes/Sessions	Number of Distinct Episodes/Sessions
Outpatient psych			Inpatient psych		
Outpatient substance abuse			Inpatient substance abuse		
IOP			RTC psych		
PHP			RTC substance abuse		

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<b>Treatment Goals for each Type of Service (specify with expected dates to achieve them.)</b>
1. 2. 3. 4. 5.

<b>Objective Outcome Criteria by which Goal Achievement is Measured</b>
1. 2. 3. 4. 5.

<b>Discharge Plan and Estimated Discharge Date</b>
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

<b>Requested Service Authorization</b>				
Procedure code:	Number of units:	Frequency:	Requested start date:	Estimated number of units to complete treatment:
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**Note:** Psychological/neuropsychological testing requests require a separate form.

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<b>Treatment Plan Coordination</b>
I have requested permission from the patient/patient's parent or guardian to release information to the PCP.
<input type="checkbox"/> Yes <input type="checkbox"/> No If not, give rationale:
Treatment plan was discussed with and agreed upon by the patient/patient's parent or guardian.

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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.