Healthy Blue

Dual Advantage

Mental Health Outpatient Treatment Report Form

Please submit this form electronically using our preferred method at **https://www.availity.com**.* This can also be submitted via fax to **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:

* Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.

Healthy Blue is the trade name of Community Care Health Plan of Louisiana, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

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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

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**	**Number of distinct episodes/ sessions**	**Level of care**	**Number of distinct episodes/ sessions**	**Number of distinct episodes/ sessions**
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
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Treatment plan coordination				
I have requested permission from the patient/patient's parent or guardian to release information to the PCP. ☐ Yes ☐ No If not, give rationale.				
Note: Psychological/neuropsychological testing requests require a separate form.				

Provider signature		**Date**	