BlueCross BlueShield of North Carolina MEDICARE

Mental Health Outpatient Treatment Report Form

Please note, this form applies to Healthy Blue + Medicare[SM] (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: ☐ 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				

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	☐ 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 Abuse

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		

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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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 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.