Blue Cross and Blue Shield of Minnesota and Blue Plus

BlueCross BlueShield Minnesota

Mental Health Outpatient Treatment Report Form

Please submit this form electronically using our preferred method at www.availity.com. This can also be submitted via fax to **1-800-505-1193**.

Identifying data		
Patient name:		
Medicaid ID:	Date of birth:	
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		

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

Symptoms that are the focus of current treatment
Progress since last review (if applicable)
Functional impairments or supports
Family/interpersonal relationships:
Job/school

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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 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 (include modifiers if applicable):	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. ☐ Yes ☐ No If not, give rationale:

Provider signature: _____ **Date:** _____

Disclaimer: Authorization indicates that Blue Cross and Blue Shield of Minnesota and Blue Plus 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.