New York | Medicaid • Medicare Advantage

Mental Health and Substance Use Nonacute Services (Outpatient Treatment) Request Form

This communication applies to the Medicaid and Medicare Advantage programs for Anthem.

Fill out completely to avoid delays. Once complete, submit using our preferred method via Availity.com or fax to:

- Medicaid: **844-452-8072**
- Medicare Advantage: **844-430-1703**

Identifying data		
Patient name:		
Medicaid ID:	DOB:	
Patient address:		
Provider information		
Provider name:		
Tax ID:		
Phone:	Fax:	
PCP name:	PCP NPI:	
Name of other behavioral health providers:		
ICD-10 diagnoses		

Medications (Please indicate changes since last report.)		
Current medications:	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 the family	
	Abuse or neglect involves a child or elder:	☐ Yes ☐ No
	Abuse has been legally reported:	☐ Yes ☐ No

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Symptoms (Include those that are the focus of current treatment.)
Progress since last review
Functional impairments/strengths (For example, note interpersonal relations, personal hygiene, work/school, etc.)
Recovery environment (Please describe support system and level of stress.)
Engagement/level of active participation in treatment
Housing
Co-occurring medical/physical illness

Family history of mental illness or substance use	
Current assessment of American Society of Addiction Medicine (ASAM) criteria. (For substance use disorders, please complete the following dimension and risk rating section.)	
Dimension (describe or give symptoms):	Risk rating:
Dimension one: acute intoxication and/or withdrawal potential (Include vitals and withdrawal symptoms.)	☐ Minimal/none ☐ Mild ☐ Moderate* ☐ Significant* ☐ Severe*
Dimension two: biomedical conditions and complications	☐ Minimal/none ☐ Mild ☐ Moderate* ☐ Significant* ☐ Severe*
Dimension three: emotional, behavioral, or cognitive complications	☐ Minimal/none ☐ Mild ☐ Moderate* ☐ Significant* ☐ Severe*
Dimension four: readiness to change	☐ Minimal/none ☐ Mild ☐ Moderate* ☐ Significant* ☐ Severe*
Dimension five: relapse, continued use or continued problem potential	☐ Minimal/none ☐ Mild ☐ Moderate* ☐ Significant* ☐ Severe*
Dimension six: recovery living environment	☐ Minimal/none ☐ Mild ☐ Moderate* ☐ Significant* ☐ Severe*
* How are moderate and higher risk ratings being addressed in treatment or discharge planning?	

Patient's treatment history including all levels of care		
Level of care:	Number of distinct episodes/sessions	Date of last episode/session
Outpatient psychiatric treatment		
Inpatient psychiatric treatment		
Outpatient substance use		
Inpatient substance use		
Chemical dependency residential treatment program		
Psychiatric medical institutes for children		

Requested service authorization				
Procedure code:	Number of units:	Frequency:	Requested start date:	Estimated number of units to complete treatment:

Treatment goals		
Goal:	Type of service:	Expected achieve date:
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

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	
• Please attach summary sheets of any applicable assessments. • Psychological/neuropsychological testing requests require a separate form.	
Treatment plan coordination	
I have requested permission from the member/member's parent or guardian to release information to the PCP/psychiatrist. ☐ Yes ☐ No If no, rationale why this is inappropriate:	
Treatment plan was discussed with and agreed upon by the member/member's parent or guardian. ☐ Yes ☐ No	
Provider's signature:	Date: