Wellpoint
District of Columbia

Mental Health Outpatient Treatment Report Form

Wellpoint District of Columbia, Inc. | Medicaid

Please submit this form electronically using our preferred method by logging into Availity from the Wellpoint DC provider website at provider.wellpoint.com/dc. For participating Wellpoint DC healthcare providers or those interested in joining our provider network, **fill out completely to avoid delays**.

Identifying data	
Enrollee's name:	
Medicaid ID:	Date of birth:
Enrollee's address:	
Provider information	
Requesting provider name:	
Tax ID:	
Phone:	Fax:
PCP name:	PCP NPI:
Name of Integrated Health Home (IHH) completing assessments:	
IHH care coordinator completing assessment (name and contact information):	

ICD-10 diagnoses		

Medications		
Current medications (indicate changes since last report)	**Dosage**	**Frequency**

Eligibility status

Children's mental health waiver:	☐ None ☐ Active ☐ New ☐ Renewal (if a renewal, please attach previous *Notice of Decision* [*NOD*])

Habilitation state plan home- and community-based services:	☐ None ☐ Active ☐ New ☐ Renewal (if a renewal, please attach previous *Notice of Decision* [*NOD*])	
Dates of *NOD* for services	From:	To:

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	
Hallucinations: ☐ Audio ☐ Visual ☐ Both ☐ Neither		
Physical or sexual abuse or child/elder abuse: ☐ Yes ☐ No		
If yes, enrollee 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	

Please complete all boxes that are applicable for this enrollee or attach additional clinical information:

Symptoms that are the focus of current treatment
Progress since last review
Functional impairments/strengths (including interpersonal relations, personal hygiene, work/school)

Recovery environment (describe, including support system, level of stress)

Engagement/level of active participation in treatment
Housing
Co-occurring medical/physical illness
Family history of mental illness or substance use

For substance use disorders, please complete the following additional information:

Current assessment of American Society of Addiction Medicine (ASAM) criteria	
Dimension (describe or give symptoms)	**Risk rating**
Dimension 1 (acute intoxication and/or withdrawal potential; include vitals, withdrawal symptoms):	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe

Dimension 2 (biomedical conditions and complications):	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe

Dimension 3 (emotional, behavioral, or cognitive complications):	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension 4 (readiness to change):	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension 5 (relapse, continued use or continued problem potential):	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension 6 (recovery living environment):	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?	

Enrollee's treatment history, including all levels of care

Level of care	Number of distinct episodes or sessions	Date of last episode or session
Outpatient psych		
Inpatient psych		
Outpatient substance use		

Inpatient substance use		
Psychiatric Medical Institute for Children		
Chemical dependency residential treatment program		
Other:		

Current authorizations being requested

Requested service authorization	
Procedure code:	Number of units:
Frequency:	Requested start date:
Estimated number of units required to complete treatment:	
Rendering provider if different than requesting (including tax ID #):	
Procedure code:	Number of units:
Frequency:	Requested start date:
Estimated number of units required to complete treatment:	
Rendering provider if different than requesting (including tax ID #):	
Procedure code:	Number of units:
Frequency:	Requested start date:
Estimated number of units required to complete treatment:	
Rendering provider if different than requesting (including tax ID #):	
Procedure code:	Number of units:
Frequency:	Requested start date:
Estimated number of units required to complete treatment:	
Rendering provider if different than requesting (including tax ID #):	

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

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 enrollee/enrollee'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 enrollee/enrollee's parent or guardian.	☐ Yes	☐ No

Provider signature:
Date: