Community **HealthFirst**™
Medicare Advantage Plans

Mental Health Outpatient Treatment Review Form Fax #206-652-7067 Service #800-942-0247

Member:_____ **Provider Name:**_____ **Provider Telephone:** _____
Member DOB:_____ **Provider Group/Clinic:**_____ **Provider Fax:** _____
Member ID:_____ **Service Address:**_____ **City/State/Zip:** _____
Provider ID/NPI:_____ **Tax ID#** _____

Mental Health/Substance Abuse History

☐**Yes** ☐**No** Previous mental health treatment inpatient/outpatient if yes:	
Level of care:	**Dates Tx:**
Level of care:	**Dates Tx:**
Level of care:	**Dates Tx:**

☐**Yes** ☐**No** Drug/Alcohol Use (For Past 12 Months) If **YES** complete the following:

Substance	Amount	Frequency	Age Began	Last Used

Clinical Assessment

Current Signs/Symptoms

☐Yes ☐No	Generalized Anxiety	☐Yes ☐No	Pressured Speech	☐Yes ☐No	Loose Associations
☐Yes ☐No	Depressed Mood	☐Yes ☐No	Weight Loss/Gain	☐Yes ☐No	Psychomotor Retardation
☐Yes ☐No	Appetite Disturbance	☐Yes ☐No	Panic Attacks	☐Yes ☐No	Concentration/Attention Problems
☐Yes ☐No	Sleep Disturbance	☐Yes ☐No	Phobias	☐Yes ☐No	Impulse Control Problems
☐Yes ☐No	Low Energy	☐Yes ☐No	Obsessions/Compulsions	☐Yes ☐No	Conduct Problems
☐Yes ☐No	Agitation	☐Yes ☐No	Circumstantial/Tangential	☐Yes ☐No	Oppositional Behaviors
☐Yes ☐No	Labile	☐Yes ☐No	Sexual Dysfunction	☐Yes ☐No	Acute Stress Disorder
☐Yes ☐No	Irritability	☐Yes ☐No	Paranoid Ideation	☐Yes ☐No	Other

Mental Status

☐Yes ☐No	Oriented x3	☐Yes ☐No	Impaired Memory	☐Yes ☐No	Delusions
☐Yes ☐No	Impaired Judgment	☐Yes ☐No	Other Cognitive Impairment	☐Yes ☐No	Hallucinations

Risk Assessment

☐Yes ☐No	SUICIDAL RISK:	☐Yes ☐No	HOMICIDAL RISK:	☐Yes ☐No	ABUSE RISK:
☐Yes ☐No	Ideation	☐Yes ☐No	Ideation	☐Yes ☐No	Verbal
☐Yes ☐No	Intent	☐Yes ☐No	Intent	☐Yes ☐No	Emotional
☐Yes ☐No	Plan	☐Yes ☐No	Plan	☐Yes ☐No	Physical
☐Yes ☐No	Means	☐Yes ☐No	Means	☐Yes ☐No	Sexual
☐Yes ☐No	Attempt	☐Yes ☐No	Attempt		

Medication Name/Dosage/Frequency:	**Rx by: Psychiatrist ☐ PCP ☐**	**Not applicable:☐**
1.		
2.		
3.		

Diagnosis (please include mental health diagnosis in Axis I if applicable)

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V: Current GAF= **Past year GAF=**

Treatment Plan

Member:_____ **ID#**_____

GOAL #
Progress/Lack of Progress on Goal:
Goal Status: Accomplished & Removed Continue Additional Progress Needed Revised –See New goal/objective
GOAL #
Progress/Lack of Progress on Goal:
Goal Status: Accomplished & Removed Continue Additional Progress Needed Revised –See New goal/objective
GOAL #
Progress/Lack of Progress on Goal:
Goal Status: Accomplished & Removed Continue Additional Progress Needed Revised –See New goal/objective

Discharge criteria/Plan:

Number of sessions required to conclude this treatment episode of care:_____

Treatment Request

Date of first visit for this episode of care:_____ **Number of sessions to date:**_____

Requested Start Date for this registration: _____

Please indicate type(s) of service requested and frequency:

☐**Diagnostic Evaluation 90791/90792 (medical)**
☐Wkly ☐Mthly ☐Qrtly ☐Other

☐**Individual Psychotherapy (45min) 90834**
☐Wkly ☐Mthly ☐Qrtly ☐Other

☐**Medication Management 99213**
☐Wkly ☐Mthly ☐Qrtly ☐Other

☐**Family Psychotherapy (60-90min) 90847**
☐Wkly ☐Mthly ☐Qrtly ☐Other

☐**Individual Psychotherapy (30min) 90832**
☐Wkly ☐Mthly ☐Qrtly ☐Other

☐**Other Code/s:**_____
☐Wkly ☐Mthly ☐Qrtly ☐Other

Clinician Signature:_____ Date: _____