



Mutual of Omaha

# OUTPATIENT TREATMENT REPORT

Mutual of Omaha

**Directions:** To request authorization of additional outpatient sessions, please fill out the information completely and fax to **BHS Precertification** at 402-351-2880. If you choose to mail this form, send the completed form to the attention of **BHS Precertification** at Mutual of Omaha, Mutual of Omaha Plaza S3, Omaha, NE 68175.

## DEMOGRAPHICS:

Case Number: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Insurer's Name: \_\_\_\_\_ Record # \_\_\_\_\_  
Practitioner's Name/Licensure: \_\_\_\_\_  
Practitioner's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## CURRENT DSM-IV DIAGNOSIS:

AXIS I: Primary: \_\_\_\_\_  
AXIS II: \_\_\_\_\_  
AXIS III: \_\_\_\_\_  
AXIS IV: \_\_\_\_\_  
AXIS V: Current: \_\_\_\_\_ Highest in past 12 months: \_\_\_\_\_

## CURRENT SIGNS AND SYMPTOMS (Circle):

Active Alcohol/Substance Use      Anger/Aggression  
Delusion                                      Depressed Mood  
Apathy                                         Decreased concentration/Inattention  
Weight/Appetite Change                 Worthlessness  
Anorexia/Bulimia                         Helpless/Hopeless  
Fatigue/Decreased Energy             Agoraphobia/Phobia  
Irritability                                  Anxiety  
Panic Attack                                 Dissociation  
Obsessions/Compulsions                 Hyperactivity  
Perpetrator of Abuse                      Oppositional  
Victim of abuse                              Paranoia  
Elevated Mood                              Grief  
Restlessness                                 Somatic Complaints  
Sexual Functioning                         Rapid speech  
Impulsivity                                  Hallucination  
Sleep    Disturbed thought process/content  
Other: \_\_\_\_\_

## CURRENT FUNCTIONING (Circle):

	None	Mild	Moderate	Severe
Family/Marital Relationships	1	2	3	4
Job/School Performance	1	2	3	4
Peer Relationships/Socialization	1	2	3	4
Financial Situation	1	2	3	4
Activities of Daily Living	1	2	3	4

Explain categories rated moderate or severe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## RISK ASSESSMENT (Circle):

**Suicidality:** None Ideation Plan Means Prior Attempt When: \_\_\_\_\_  
**Homicidality:** None Ideation Plan Means Prior Attempt When: \_\_\_\_\_  
Psychiatric Hospitalization in past: 3months 6 months 12 months Other: \_\_\_\_\_  
Other risk behaviors: \_\_\_\_\_

## MEDICATIONS:

Has patient been evaluated for medications?      Yes      No  
Is patient on psychotropic medications?            Yes      No  
If yes, is patient compliant with medications?    Yes      No  
Is patient seeing a psychiatrist/PCP regularly?    Yes      No

List current psychotropic medications with dosage/frequency/start date:  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

## TREATMENT PLAN:

\_\_\_\_ Improved functioning/symptom reduction and discharge from treatment  
\_\_\_\_ Transfer to support groups or self-help and discharge from treatment  
\_\_\_\_ Provide ongoing supportive counseling and maintain stabilization of symptoms  
\_\_\_\_ Provide ongoing medication management  
\_\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_



**OUTPATIENT TREATMENT REPORT**

Patient Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

**NUMBER OF ADDITIONAL SESSIONS TO TERMINATION:**

(Please check)

\_\_\_\_ Less than 5                      \_\_\_\_ 10-14  
\_\_\_\_ 5 – 9                                \_\_\_\_ 15 or more (explain)  
\_\_\_\_\_

Frequency of sessions:    Weekly    Every two weeks    Monthly  
Other: \_\_\_\_\_

**NUMBER OF SESSIONS REQUESTED:**

**90804** Psychotherapy for 20-30 minutes \_\_\_\_\_  
**90806** Psychotherapy for 45-50 minutes \_\_\_\_\_  
**90847** Family psychotherapy for 45-50 minutes \_\_\_\_\_  
  
**90862** Medication management \_\_\_\_\_  
**90805** Therapy with medication management for 20-30 min \_\_\_\_\_  
**90807** Therapy with medication management for 45-50 min \_\_\_\_\_  
  
**90853** Group Therapy\* \_\_\_\_\_ (see below)  
  
**S9480** Intensive Outpatient Therapy: \_\_\_\_\_  
For IOP: Length of sessions: \_\_\_\_\_  
How many sessions per week \_\_\_\_\_

**Other:** \_\_\_\_\_

\*Request for **Group Therapy** requires completion of Group Addendum Form.  
To obtain form, contact **BHS Precertification** at 1-800-228-0286 x7765.  
\*\*If Group Therapy provider is a different practitioner than previously indicated:  
Practitioner's Name: \_\_\_\_\_  
Licensure: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**OTHER TREATMENT OR SERVICES PATIENT RECEIVES:**

1. \_\_\_\_\_  
2. \_\_\_\_\_

**TREATMENT FREQUENCY:**

Date first seen: \_\_\_\_\_ Date last seen: \_\_\_\_\_  
Total visits seen: \_\_\_\_\_  
Number of sessions used since last authorization: \_\_\_\_\_  
Date you request this authorization to begin if possible: \_\_\_\_\_

**PROPOSED TREATMENT:**

**Problem #1:** \_\_\_\_\_  
Measurable outcome: \_\_\_\_\_  
Treatment plan: \_\_\_\_\_  
\_\_\_\_\_

**Problem #2:** \_\_\_\_\_  
Measurable outcome: \_\_\_\_\_  
Treatment plan: \_\_\_\_\_  
\_\_\_\_\_

**Problem #3:** \_\_\_\_\_  
Measurable outcome: \_\_\_\_\_  
Treatment plan: \_\_\_\_\_  
\_\_\_\_\_

**Estimated discharge date:** \_\_\_\_\_  
**Discharge plan:** \_\_\_\_\_  
\_\_\_\_\_

**Additional comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Practitioner's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

FOR MUTUAL OF OMAHA USE ONLY

Authorization with CPT codes: \_\_\_\_\_ Start date: \_\_\_\_\_ End date: \_\_\_\_\_  
Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_