

Medication Treatment Report

This form applies to requests for 90862 only. It must be completed in its entirety in order to be processed for authorization.

FOR CONFIDENTIAL USE ONLY

OptimaHealth™

Behavioral Health Services

44417 Corporation Lane Ste 250
Virginia Beach, VA 23462

Telephone: (757) 552-7174 Fax: (757) 552-7176

1. Patient Name		2. Date of Birth (mo/day/yr)		3. Age	
4. Member ID#		5. Member SS#			

Directions: Please submit an updated Medication Treatment Report at least 2 weeks prior to your last authorized session. Report must be complete and legible in order to be reviewed. Incomplete or illegible forms will be returned to Provider and may delay processing.

6. When did this episode of care begin ? _____

7. Diagnosis (Please address all five axes.)

Axis I				
Axis II				
Axis III				
Axis IV				
Axis V	Current		Past Year	

8. Current Level of Functioning (Please evaluate all areas.)

Area	No Impairment 0	Minimal Impairment 1	Mild Impairment 2	Moderate Impairment 3*	Severe Impairment 4*	Profound Impairment 5+ *
Occupational/Academic						
Social/Familial						
Physical						
Psychological						

9. Medication(s)

Name, Dosage, Frequency of Medication	Serum Level	Desired Outcome	Date Medication Started or Changed	Prescribing Physician

Target symptoms: _____

Patient Name

Member Number

10. Names of Other Providers Currently Treating Patient

Provider	Licensure	Modality (IT, FT, GT)	Frequency (#x wk, mo, yr)

11. Have you RECEIVED any clinical information from the Primary Care Physician? No Yes From the therapist? No Yes
 Have you PROVIDED any clinical information to the Primary Care Physician? No Yes To the therapist? No Yes

12. Reasons for continuing medication _____

13. Specifics of authorization request

Number of add'l sessions requested	Requested frequency of sessions

14. Additional Comments _____

My signature below denotes that I am rendering face-to-face clinical services for the above-named patient. The above statements are true, and all appropriate releases have been obtained. My signature also verifies that the fax number below is accurate and CONFIDENTIAL.

15. Name of Practice 16. Provider ID#
 17. Print Provider Name/Current Licensure (Academic credentials will not suffice.) 18. Telephone ()
 19. Fax ()
 20. Address 21. Zip Code
 22. Provider Signature 23. Date

Care Manager _____	Date Reviewed _____	FOR OFFICE USE ONLY	DISPOSITION: # Sessions Authorized _____	Denied _____
Peer Reviewer (if any) _____				