BlueCross BlueShield of Nebraska

7261 Mercy Road
Omaha, Nebraska 68180-0001
www.bcbsne.com

FEP Service Omaha 390-1879
Toll Free 800-223-5584
Hearing Impaired 390-1888 TTY/TDD

Federal Employee Program Outpatient Treatment Plan

NO ACTION WILL BE TAKEN ON INCOMPLETE FORMS. THEY WILL BE RETURNED.

Provider(s): _____ Phone No.: _____

_____

BCBSNE Provider #: _____ Date of Referral: _____
AND
Provider Tax ID #: _____ Fax No.: _____

Patient's Name:	Sex:	Date of Birth:	Age:	Subscriber ID Number:

Address:	City/State/Zip:

Employer/School:

Spouse/Mother/Father:	Home Phone Number: Work Phone Number:

Chief Complaint:	Precipitating Events:

Axis I & DSM IV Code:	Axis II:	Axis III:	Axis IV:	Axis V:

SYMPTOMS (FILL IN ALL THAT APPLY)

DEPRESSION
- ☐ Appetite
- ☐ Sleep
- ☐ Concentration
- ☐ Guilt

ANXIETY
- ☐ Worry
- ☐ Panic/Phobia
- ☐ Somatic Complaints

MANIA
- ☐ Energy
- ☐ Insomnia
- ☐ Grandiosity

PSYCHOSIS
- ☐ Hallucinations
- ☐ Delusions
- ☐ Disorientation

SUBSTANCE ABUSE
- ☐ Dependence
- ☐ Withdrawal
- ☐ Legal Problems
- ☐ Medical Complications

OTHER (List)

MENTAL STATUS (FILL IN ALL THAT APPLY)

ORIENTATION
- ☐ Oriented
- ☐ Disoriented

SPEECH
- ☐ WNL
- ☐ Incoherent
- ☐ Rapid
- ☐ Tangential

APPEARANCE
- ☐ WNL
- ☐ Disheveled
- ☐ Inappropriate

COGNITION
- ☐ Good
- ☐ Impaired

SOCIABILITY
- ☐ Average
- ☐ Engaging
- ☐ Aloof

OTHER (List)

RISK ASSESSMENT (FILL IN ALL THAT APPLY)

SUICIDE RISK
- ☐ None
- ☐ Low
- ☐ Moderate
- ☐ High

Past 3 Months
- ☐ Ideation
- ☐ Intent
- ☐ Plan
- ☐ Gesture
- ☐ Attempt

VIOLENCE/HOMICIDE
- ☐ None
- ☐ Low
- ☐ Moderate
- ☐ High

Past 3 Months
- ☐ Ideation
- ☐ Intent
- ☐ Plan
- ☐ Gesture
- ☐ Attempt

ABUSE/VIOLENCE
- ☐ None
- ☐ Low
- ☐ Moderate
- ☐ High

Past 3 Months
- ☐ Domestic
- ☐ Child
- ☐ Sexual
- ☐ Other

Describe above Attempts:

PRESENTING PROBLEM

- ☐ Psychiatric
- ☐ Emotional
- ☐ Marital
- ☐ Family
- ☐ Work/School
- ☐ Financial
- ☐ Legal
- ☐ Care Giver
- ☐ Substance Use/Abuse

PREVIOUS TREATMENT (FILL IN ALL THAT APPLY)

PSYCHIATRIC		DISCHARGE
Inpatient	☐ N ☐ Y	☐ <30 Days ☐ <1 yr. ☐ > 1 yr.
Outpatient	☐ N ☐ Y	☐ <30 Days ☐ <1 yr. ☐ > 1 yr.
Med/Mngt	☐ N ☐ Y	☐ Current ☐ <1 yr. ☐ > 1 yr.
SUBSTANCE		**DISCHARGE**
Detox	☐ N ☐ Y	☐ <30 Days ☐ <1 yr. ☐ > 1 yr.
Inpatient Stabilize	☐ N ☐ Y	☐ <30 Days ☐ <1 yr. ☐ > 1 yr.
Outpatient	☐ N ☐ Y	☐ <30 Days ☐ <1 yr. ☐ > 1 yr.

FUNCTIONAL PROGRESS (FILL IN ALL THAT APPLY)

	Impairment Level				Anticipated Dischg. Level			
	None	Mild	Mod	Severe	None	Mild	Mod	Severe
	1	2	3	4	1	2	3	4
Marriage/Family	☐	☐	☐	☐	☐	☐	☐	☐
Job/School	☐	☐	☐	☐	☐	☐	☐	☐
Social Relations	☐	☐	☐	☐	☐	☐	☐	☐
Social Activities	☐	☐	☐	☐	☐	☐	☐	☐
ADL Activities	☐	☐	☐	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐	☐	☐	☐

Patient Name:	Subscriber I.D. No.:

TREATMENT SUMMARY

Treatment Focus: (Fill All that Applies) ☐ Improved Decision Making ☐ Improved Functional Status ☐ Psychotherapy ☐ Improved Coping Skills	For Extended Visit Request please document progress since last treatment plan: ☐ Minimal Change ☐ Much Improved ☐ Somewhat Improved ☐ No Improvement ☐ Deteriorated ☐ Other (List)	Closure Status: (Fill All that Applies) ☐ Symptom Reduction ☐ Improved GAF ☐ Transfer to Self Help ☐ Implement Discharge Plan ☐ Other (List)

MEDICATIONS			MEDICATIONS (List)
Current Medications:	☐ No	☐ Yes	
If Yes:	☐ Medical	☐ Psychiatric	
If Yes, Coordinated Care?	☐ No	☐ Yes	
Prescribing Physician:	☐ Medical	☐ Psychiatric	

CLINICAL PLAN: Summarize clinical strategy relative to treatment interventions and member symptoms including goals for treatment.

☐ Medication checks only. Please indicate frequency: _____

Goals:

Planned Interventions:

Date of First Visit:	Date Last Seen:	Number of Sessions to Date this Episode:

Frequency of Visits:	Number of Visits Requested:

Date of Evaluation:	Provider's Signature:	Date:

PLEASE FAX COMPLETED TREATMENT PLAN TO THE UTILIZATION MANAGEMENT DEPARTMENT AT: 402-343-3429

For questions regarding this authorization, please call the Utilization Management Department at 402-390-1870 or toll free at 800-247-1103.

FOR BLUE CROSS AND BLUE SHIELD OF NEBRASKA USE ONLY:

UM Review Date:	Reviewer:

Number of Visits Authorized:	Expiration Date:

Comments: