South Carolina Department of Health and Human Services Mental Health Form

FILL OUT COMPLETELY TO AVOID DELAYS

Beneficiary's Name:				Organiza			
Medicaid ID#:		****		Center's	Name:		
Date of Birth:				Service L		ddress:	
Individual NPI:			City & St		WWW VIII		
DSM-IV TR Diagnosis					*****		
Axis I			Axis II _	/		Axis III/	
Date first seen: Date of last service		:	# o	f additiona	l visits requested:		
Comparet Clinical Inform							
Current Clinical Informa Aggression	0 1 2 3 4	1. Scale U=No	one, I=Mild,		, 3=Severe, 2 3 4	4≈Extreme) Relationship Problems	01224
Alcohol/Substance Use	01234	Depressions Hallucinations				Side Effects	01234
		Fianucinations		01234		Side Effects	01234
Anxiety/Panic	01234			01234		Sleep Effects	0 1 2 3 4
Appetite Disturbance	01234	Job/School Problems		0.1	2 3 4	Sleep Disturbance	01234
Attention/Concentration	01234	Mania		0.1	234	Weight Loss	01234
Deficit in ADLs	01234	Medical Illness		0.1	2 3 4	Other	01234
Delusions	01234	0 1 2 3 4 Memory		0.1	2 3 4	Current Stressors	01234
	Nam		Dose		90832 90834 Freque	ency Side	H0002 Effects
11011	1						
◇ New ◇ New	2						
♦ New	3						
Compliance	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	>90%	< >	50-90%	· <	> <50%	
Reasons for Noncompliance:			·				
Physician/Non physician i	Practitioner's Nar	— ne	() Phone:		()_		
- F			I IIVIIVI		тах		
Physician/Non physician I	Practitioner's Sign	nature	Date				

Disclaimer: Authorization indicates that SCDHHS determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered. The Physician Assistant is not authorized to sign this form.

Behavioral Health Services Post Office Box 8206 Columbia, South Carolina 29202-8206