**Mental Health checklist**

NOTE\*\*

If request is for an Initial Review, submission of Comprehensive Assessment is required.

If request is for a Continued Treatment Review, submission of most recent treatment plan and progress summary is required.

1. Provider Contact Name:
2. Provider Contact Number:
3. Is This a Retro Review: Yes / No
* If Retro Request, date notified of Medicaid eligibility:

 4. What current edition DM or ICD diagnosis does the Patient have?

5. What symptoms is the Patient experiencing that require services?

6. How is the illness affecting functioning (relationships with others, school/job performance, ADLs)?

7. How many visits has Patient kept out of the last 5 authorized visits? Please do not include excused absences (e.g., MD appointments, job interview, influenza) when calculating the number of visits not kept.

 8. Please describe the patient’s support system.

 9. Is patient on any medications? If so, please list.

 10. Is there a history of substance abuse by the patient? If so please explain.

 11. Has there been any exposure to physical abuse, sexual abuse, anti-social behavior, or other traumatic events? If so please explain.