BlueCross BlueShield Nebraska

1919 Aksarben Drive • PO Box 3248
Omaha, Nebraska 68180-0001
Member Service: 800-642-8980 or 402-390-1820
Health Service Programs: 800-247-1103

Outpatient Treatment Plan

Please fax completed form to Blue Cross and Blue Shield of Nebraska (BCBSNE): 402-343-3444.
For questions, please call 800-247-1103.
Incomplete forms will be returned.

Provider Name:	Provider BCBSNE # or Tax ID # :		Specialty:	
Address:	City / State / ZIP:			
Phone Number:	Fax Number:			
Patient Name:	BCBSNE Member #:	Date of Birth (mm/dd/yyyy):	Age	Gender ☐ F ☐ M ☐ O
Current DSM Diagnosis(es)(ICD-10 Codes):				

List current symptoms: _____

_____

Risk:	None	Mild	Moderate	Severe	Functional Impairment:	None	Mild	Moderate	Severe
Suicide/Self Harm	☐	☐	☐	☐	Marital/Family	☐	☐	☐	☐
Aggression	☐	☐	☐	☐	Work/School	☐	☐	☐	☐
Substance Use Disorder	☐	☐	☐	☐	Social/Social Support	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐	ADL Activities	☐	☐	☐	☐
Medical Issues	☐	☐	☐	☐	Eating/Sleeping	☐	☐	☐	☐

Has the client had a psychotropic medication evaluation? ☐ Yes ☐ No ☐ Planned ☐ Unknown

Current medications: _____

_____

Are you coordinating with other behavioral or medical providers? ☐ Yes ☐ No ☐ Refused

Is family or support involved in treatment? ☐ Yes ☐ No ☐ Refused ☐ NA

Treatment goals and progress related to symptoms:

Discharge plan (such as self-help, community support, maintenance outpatient):

_____

Date last seen: _____ Frequency of visits: _____ Number of visits requested: _____

Anticipated number of visits until goals are achieved: _____

Provider Signature: _____ Date: _____