Military One Source Case Activity and Billing Form

Instructions: Please use CAPITAL letters. **ALL** information is required to ensure payment. Submit within 15 days of the Date of Service. Keep a copy for your records.

Statement of Understanding (SOU) Signed: O Yes O No (All participants must sign the SOU)

Authorized Participant Information: *Last Name* *First Name* *MI*

Participant's Address: *Street Address* *City*

State *ZIP Code* **Date of Birth** (mm/dd/yy) / / **Participant Home Phone** - -

Participant Gender: O Female O Male **No Session/ Missed Appt.:** O Yes O No ('Yes' if Closing Case w/o session)

Billing Information: **Date of Service** (mm/dd/yy) / /

Mode of Delivery:
O Face-to-Face O Video
O Telephonic O Online

Authorization Number

Counselor: *Last Name* *First Name* *MI*

Counselor Billing Address:

Street *City*

State *ZIP Code* **Tax ID Number or SSN:** **NPI Number:**

Counselor's Phone: - -

Counselor's Signature: _____

Date: _____

Total Sessions Billed: _____

Number of Sessions Used at Case Closing: _____

Assessed Problem (Choose 1 Problem/Issue):

O Z63.0 Relational Distress with Intimate Partner
O Z71.9 Other Counseling or Consultation
O Z60.0 Phase of Life Problem
O Z62.820 Parent-Child Relational Problem
O Z56.9 Problem Related to Employment
O Z63.5 Disrupt. of Family by Separation/Divorce
O Z63.4 Uncomplicated Bereavement
O Z56.82 Problem Related to Current Military Deployment Status
O Z62.898 Child Affected by Parental Rel. Distress
O Z91.82 Personal History of Military Deployment
O Z59.9 Housing or Economic Problem
O Z91.411 History of Partner Psychological Abuse
O Z91.412 History of Spouse or Partner Neglect
O T74.11 Physical Abuse by Nonpartner (confirmed)
O T76.11 Physical Abuse by Nonpartner (suspected)
O T74.31 Psych. Abuse by Nonpartner (confirmed)
O T76.31 Psych. Abuse by Nonpartner (suspected)
O T74.21 Sexual Abuse by Nonpartner (confirmed)
O T76.21 Sexual Abuse by Nonpartner (Suspected)
O Z91.410 History of Partner Violence, Physical
O Z91.410 Hist. of Partner Violence, Sexual
O Z62.810 Hist. of Physical Abuse as Child
O Z62.810 Hist. of Sexual Abuse as a Child
O Z62.811 Hist. of Psych. Abuse as a Child
O Z72.9 Problem Related to Lifestyle
O Z63.8 High Emotional Level Within Fam.
O Z65.8 Problem Related to Psychosocial
O Z59.9 Prob. Related to Social Environ
O Z91.49 History of Psychological Trauma
O Z65.4 Victim of Crime
O Z60.3 Acculturation Difficulty
O Z60.4 Social Exclusion or Rejection
O Z60.5 Target of (perceived) Discrimination or Persecution
O Z62.891 Sibling Relational Problem
O Z56.8 Religious or Spiritual Problem
O Z65.5 Exposure to Disaster or War
O Z72.810 Child/Adolescent Antisocial Beh.
O Z60.2 Problem Related to Living Alone
O Z91.89 Other Personal Risk Factors
O Z62.29 Upbringing Away From Parents
O Z59.6 Low Income
O R41.83 Borderline Intellectual Functioning
O Z59.0 Homelessness
O Z59.2 Discord w/ Neighbor or Landlord
O E66.9 Overweight or Obesity
O Z65.2 Problem Related to Release From Prison
O Z65.3 Prob. Related to Legal Circumstance
O Z91.5 Personal History of Self-Harm
O Z64.0 Problem w/ Unwanted Pregnancy
O Z64.1 Problem Related to Multiparity
O Z55.9 Academic or Education Problem
O Z59.1 Inadequate Housing
O Z59.3 Problem Living in Residential Inst.
O Z59.4 Lack of Adequate Food/ Water
O Z59.5 Extreme Poverty
O Z59.7 Insufficient Social Insurance, or Welfare Support
O Z75.3 Unavailability of Health Care Facilities
O Z75.4 Unavailability of Helping Agencies

Participant Last Name | | | | | | | | | | |

First Name | | | | | | | | | | |

Type of Counseling Provided:
O Individual O Couple O Family

Military Identification card viewed and verified by provider?:
O Yes O No

Does participant have any DSM diagnoses? O Yes O No *(If yes, refer case to medical/mental health treatment)*

Is issue related to deployment? O Yes O No Is issue related to reintegration? O Yes O No

Risk and Functional Assessment: Indicate participant's level of impairment at time of session and at Case Closing:

Member's risk to self……	O0	O1	O2	O3
Member's risk to others…….....	O0	O1	O2	O3
Mood Disturbances (depression or mania)……..	O0	O1	O2	O3
Anxiety……	O0	O1	O2	O3
Thinking / Cognition / Memory / Concentration….....	O0	O1	O2	O3
Impulse / Reckless / Aggressive Behavior…….....	O0	O1	O2	O3
Activities of Daily Living Problems……	O0	O1	O2	O3
Medical / Physical Condition……..	O0	O1	O2	O3
Substance Abuse / Dependence…….....	O0	O1	O2	O3
Job / School Performance……..	O0	O1	O2	O3
Social Functioning / Relationship / Marital / Family…	O0	O1	O2	O3

0 = No Evidence of Impairment
1 = Mild Impairment
2 = Moderate Impairment
3 = Severe Impairment (must be significant impairment)

Counseling Goals: (At least one goal is required)

1.	O Met O Partially Met O Not Met O No Change
2.	O Met O Partially Met O Not Met O No Change
3.	O Met O Partially Met O Not Met O No Change

Mental Health Treatment History Assessed O Yes O No Notes: _____

Substance Abuse Treatment History Assessed O Yes O No Notes: _____

Strength, Skills, Aptitude and Interests Assessed O Yes O No Notes: _____

Supports Assessed O Yes O No Notes: _____

	None/Denies	Current	History
Domestic Violence	O	O	O
Child Abuse/Neglect	O	O	O
Sexual Assault	O	O	O
Sexual Abuse (of a minor)	O	O	O

High Risk Case: O Yes O No
Reviewed with MOS consultant? O Yes O No
If yes, w/ whom?
(Consultant's name) _____
Was a safety plan developed? O Yes O No

Please note whether a legally required report has been filed:

By Whom:_____When:_____Where:_____

Case Summary Note: (Please include critical issues or events addressed in session)

Billing Type: **O** Interim **O** Final

Case Closing/Final Session *(Must be filled out upon Case Closing or after 30 days of no contact)*

Closing Reason:

O Participant's case successfully resolved
O Participant withdrew/dropped out before the completion of services
O Participant discontinued for other reasons
O Out of Scope- Escalated to Crisis
O Out of Scope- Non Crisis

Reasons Deemed Out of Scope (If Indicated)

O Risk to Self **O** Risk to Others
O Currently Receiving Mental Health Tx.
O Currently Prescribed Psych. Medication
O Diagnosed w/ Mental Health Condition
O Fitness for Duty or Court Ordered
O Psych. Hospitalization **O** Illegal Activity
O Domestic Abuse **O** Child Abuse
O Substance Abuse **O** Sexual Assault/Rape

Overall Status of Goals:

O Goals Met
O Partially Met Goals
O Goals Not Met

Case Disposition:

O No Referral made to other resources
O Referral for other resources accepted
O Referral for other resources declined
O Did Not Keep Initial Appointment
O Discontinued Counseling

Fax to 877-762-1356 or submit electronically via ProviderConnect

Referral Type (check all that apply)

O No referral beyond MOS
O TRICARE
O Military Treatment Facility
O Victim Advocate
O Sexual Assault Response Coordinator
O Family Advocacy Program
O Other Medical
O Other Substance Abuse
O Other Mental Health
O Community Resource
O Red Cross

This form is due within 15 days of the date of service.