QualChoice® HEALTH INSURANCE

Plan of Care Form

Section I: Patient Information			
Patient's Legal Name	Date of Birth	QualChoice ID Number	Date of Initial Visit
Brief Psychiatric History			
Current Symptoms			

Section II: Medical, Psychiatric, Substance Use Disorder Information
Diagnosis
Diagnosis
Diagnosis
Medication and Dosage
Treatment Plan

Section III: Goals/Progress with Goals for Continued Treatment	
1.	
2.	
3.	
Number and Frequency of Visits Requested	Number of Sessions Used to Date

Section IV: Provider Information			
Provider Name	Provider QualChoice ID Number	Provider Phone Number	
Provider Address (required)	City	State	ZIP
Provider Signature (required)		Date	

Section V: Instructions	
Please FAX or mail completed form to:	QualChoice Attn: Care Management Department P.O. Box 25610 • Little Rock, AR 72221 Fax: 833.681.2498