

Kansas Health Solutions  
**Clinical Update**

**Instructions: Submit every eighteen (18) months or whenever there is a significant clinical change.**

<b>Member Name:</b> _____	<b>Date of Birth:</b> _____
Last                      First                      Middle	mm/dd/yy
<b>Medicaid Number:</b> _____	<b>Social Security Number:</b> _____

<b><u>COMPLETE IF PROVIDER IS PART OF AN AGENCY OR GROUP PRACTICE</u></b>
<b>Provider Agency:</b> _____

<b><u>COMPLETE IF PROVIDER IS IN INDEPENDENT PRACTICE (I.E., NOT PART OF AN AGENCY OR GROUP PRACTICE)</u></b>
<b>Provider Name:</b> _____
Last                      First                      Middle

**Are any services to be provided court ordered?**

Yes     No

**If Yes, specify the applicable service category. [More than one option may be checked]**

- Evaluation [Any court ordered evaluation other than Medication Evaluation]
- Outpatient Therapy [Individual, Group and Family Therapy]
- Outpatient Medical Services [All Medical Services including Medication Evaluation]
- Other

**Primary Diagnosis:**

Indicate Axis Number	Code	Description

**Secondary Diagnosis(es): [At least one secondary diagnosis must be noted, which may include 799.9 or V71.09]**

Indicate Axis Number	Code	Description

**Functional Level (GAF):** \_\_\_\_\_

**Special Needs: [More than one option may be checked]**

- |  |  |
|--|--|
| <input type="checkbox"/> Severe and persistent mental illness (SPMI)                                   | <input type="checkbox"/> Pregnant and using substances |
| <input type="checkbox"/> Serious emotional disturbance (SED)   | <input type="checkbox"/> Using intravenous drugs       |
| <input type="checkbox"/> Dual diagnosis (Mental illness/substance abusing)                             | <input type="checkbox"/> Not Applicable                |
| <input type="checkbox"/> Dual diagnosis (Mental illness/developmental disabilities/mental retardation) |  |

**Member continues to meet medical necessity criteria (i.e., authority, purpose, scope, evidence, and value) as detailed in the Provider Manual:**                       Yes                       No

Completed By: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yy)

First Name                      Last Name

Contact Number: \_\_\_\_\_