Choice Program - Episode Completion Form

Veteran's Name:	**DoD ID/Benefits # or Sponsor SSN:**
Date Completed:	**VA Auth Number:**

1. Veteran's Address:	2. Patient DOB: Age:
2. City:	State: Zip:
3. Telephone:	Telephone:
4. Veteran's Service Branch: ☐Army ☐Navy ☐USAF ☐USMC ☐USCG ☐Other	
5. Other Insurance: ☐ yes ☐ no If yes, please specify:	

6. Provider Name:	License Type:
7. Provider Telephone:	Fax:
8. Provider Address:	
City:	State: Zip:
9. Provider TIN:	Provider NPI:

10. **DSM-V Diagnosis** 1. _____ 2. _____ 3.	11. **Co-Occurring Medical Conditions (Relevant to Treatment)** 1. _____ 2. _____ 3.

12. Has the patient had a psychiatric hospitalization in the last 90 days: ☐ yes ☐ no

13. TREATMENT SUMMARY: (Please provide a brief and succinct summary of the results of treatment)

13. TREATMENT SUMMARY CONT.: (Please provide a brief and succinct summary of the results of treatment)

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14. DISCHARGE PLAN:

1.

2.

3.

Resources Provided:

1.

2.

3.

Final Session Date:

Provider Signature: _____ Credentials: _____ Date: _____

Please fax the completed form to: 1-866-284-3736 or Upload via the Provider Portal

Note: HIPAA authorization requirements do not apply to protected information used for treatment, payment, or health care operations including medical records requested for the provision of health care services. Privacy Act Statement - This information is protected under the Privacy Act of 1974 and shall be handled as "for official use only." Violations of this may be punishable by fines, imprisonment, or both.