PLEASE PRINT

HealthChoice and PAC Substance Abuse Ambulatory Concurrent Review Form

ALL FIELDS ARE REQUIRED

Attach more pages if needed

Please complete all sections. This information has been disclosed to you from records protected by Federal confidentiality rules (CFR 42 – Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1. [ ] **Level I: Traditional Outpatient** [ ] **Level II.1: Intensive Outpatient** [ ] **OMT: Methadone Maintenance**

2. MCO Name: **Date Submitted to MCO:** _____/_____/_____ **Time:**

3. Client's Name: (Last) , **(First)**

4. Client's Date of Birth: _____/_____/_____	**5. Client's Gender:** M: _____ F: _____	**6. Client's MA #:**	**7. Client's MCO #** (if different) **:**

8. Other Insurance Group # (if applicable) **:**	**9. Client's Complete Address:**	**10. Client's Phone Number:** ( )

11. Treatment Facility Name: Address: Phone: ( ) Fax: ( )	**12. Facility MA # :**	**13. Facility Tax ID # :**

14. Primary Care Physician (if known) **:**

15. Treatment Episode Start Date: _____/_____/_____	**16. Requested Start Date for MCO Authorization:** _____/_____/_____	**17. Client Pregnant?:** Y N If yes, Due Date (if known) **:** Scheduled to receive prenatal care? Y N

18. Updated Diagnosis Since Last Authorization Period (Please write again using DSMIV Codes even if there are no changes):

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V (GAF):

19. List ALL Reported Current Medications AND Current Medications prescribed by Substance Abuse treatment provider (such as Methadone or Suboxone). Attach additional pages if necessary.

Name of Medication	Dosage	Frequency	Adherence (e.g., Yes, No, Unknown)

20. Response to Treatment – Please ATTACH COMAR required treatment plan. This treatment plan should list specific gains made since initial treatment plan and all remaining symptoms with frequency and severity. The updated treatment plan should also provide justification for continuation of treatment.

21. Alcohol/Drug Screens/Breathalyzer Results Last 6 Tests – Include positive screen for medications not prescribed by the treatment program. Attach additional pages if necessary.

	Date of Specimen	Negative	Positive (if positive, what substances were positive and level present)
1.			
2.			
3.			
4.			
5.			
6.			

22. Is client currently abusing substances? Y N
If yes, list interventions to address usage (e.g., administrative detox, change in level of care):

23. Treatment

	Code	# of Sessions (S) OR # of Units (U) (circle one)	Session/Unit Conversion
[ ] Individual	H0004	[ ] S or U per week	1 Session = 4 Units (15 minutes per unit)
[ ] Group	H0005	[ ] S or U per week	1 Session = 1 Unit (60 – 90 minutes)
[ ] Intensive Outpatient	H0015	[ ] days/week & [ ] total hrs/week	Weekly total must be ≥ 9 hrs (Min.2 hrs/day – max. 4days/wk)
[ ] Methadone Maintenance	H0020	Per Week	1 Session = 1 Unit (Must include at least one face to face encounter with counselor)

24. Anticipated Discharge Date from current level of care (if known): _____/_____/_____

25. After Care Plan:

26. Comments (anything not addressed in the treatment plan but supports request for continued level of care, e.g. employment, family, housing, health status, socialization, support system):

27. Treatment Clinician's Name:

Printed _____ Clinician Signature _____ Credentials _____ Date _____

Treatment Clinician's Email Address _____ Treatment Clinician's Phone Number _____