

HealthChoice Substance Use Disorder Ambulatory Concurrent Review Form

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 participant.

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

2. MCO Name: _____ Date Submitted to MCO: _____ Time: _____ am/pm

3. Participant's Name: (Last) _____, (First) _____

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

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

11. Treatment Facility Name: _____ 12. Facility MA # : _____ 13. Facility Tax ID # : _____
Address: _____
Phone: _____ Fax: _____

14. Primary Care Physician (if known) :

15. Treatment Episode Start Date: _____ 16. Requested Start Date for MCO Authorization: _____ 17. Participant 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.

