

PLEASE PRINT

HealthChoice Substance Use Disorder Notification Form

ALL FIELDS ARE REQUIRED

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Attach more pages if more space is needed

Please complete all sections. The information has been disclosed to you from records protected by Federal Confidentiality rules (CFR 42, Part 2). The Federal Ruled prohibit 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, Part2. 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 Number: _____ 7. Participant's MCO Number (if different) : _____

8. Other Insurer Group # (if applicable) : _____ 9. Participant's Complete Address: _____ 10. Participant'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. Participant Pregnant?: Y N
If yes, Due Date (if known) : _____
Scheduled to receive prenatal care? Y N

18. Substance Abuse	Severity	Frequency	Method	Date of Last Use
Primary:				
Secondary:				
Tertiary:				

19. Prior Substance Abuse Treatment History - Last 3 Years (if known)

Name of Treatment Facility	Treatment Type (e.g., OP, IOP, OMT)	Dates of Service	Treatment Status	
			Successful	Unsuccessful

20. List ALL Reported Current Medications (Including Medical, Psychiatric, & Sub. Abuse such as: Suboxone & Methadone) – Attach additional pages if necessary

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

21. Diagnosis/ DSM IV-R – Please complete all Axes

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V (GAF):

22. ASAM PPC (Circle one for each Level of Risk)

Level of Risk

	0	1	2	3	4
Dimension I: Withdrawal					
Dimension II: Biomedical Conditions and Complications					
Dimension III: Emotional/Behavioral Conditions and Complications					
Dimension IV: Treatment Acceptance					
Dimension V: Relapse/Continued Use Potential					
Dimension VI: Recovery Environment					

23. Treatment

	Code	# of Sessions (S) or Units (U) per week (circle one)	Session/Unit conversion
<input type="checkbox"/> Individual	H0004	[] S or U per week	1 Session = 4 Units (15 minutes per unit)
<input type="checkbox"/> Group	H0005	[] S or U per week	1 Session = 1 Unit (60-90 minutes)
<input type="checkbox"/> Intensive Outpatient	H0015	[] days/week & [] total hrs/week	Weekly total must be ≥ 9 hrs (Min.2 hrs/day – max. 4 days/wk)
<input type="checkbox"/> Methadone	H0020	Per week	1 Session = 1 Unit (Must include at least one face to face encounter with a health professional)

24. Anticipated discharge date from this Level of Care (if known): 12/01/2011

25. Comments – optional (please use additional pages if necessary)

26. Treatment Clinician’s Name:

Printed

Clinician Signature

Credentials

Date

Treatment Clinician’s Email Address

Treatment Clinician’s Phone Number