Continuing Care Treatment Plan Form

Demographics

CDR Number: _____ Revised? ☐ YES ☐ NO

Primary Enrollee
Last Name: _____ First Name: _____ Contract Number: _____

Client
Last Name: _____ First Name: _____ Date of Birth: ____ / ____ / ____

Case Open Date: ____ / ____ / ____ Primary Diagnosis: _____ Secondary Diagnosis: _____

Section A – Detoxification

Client admitted for detoxification? ☐ YES ☐ NO Was an extension beyond 72 hours requested and approved? ☐ YES ☐ NO

Section B - Reimbursable Substance Abuse Intervention (please √ one only per section)

01 ☐ Detox	02 ☐ IP Residential	03 ☐ Halfway House	04 ☐ Partial Hospitalization	05 ☐ Initial OP Interview
06 ☐ IOP	07 ☐ THC	08 ☐ Full Ind. Therapy	09 ☐1/2 Ind. Therapy	10 ☐ Family Therapy
11 ☐ Group Therapy	12 ☐ Med. Mgt.	13 ☐ 15 Min. Op Cons	14 ☐ 30 Min OP Cons	15 ☐ 40 Min OP Cons
16 ☐ 60 Min OP Cons	17 ☐ 80 Min OP Cons	18 ☐ Provider Denial	19 ☐ Emergency Room	20 ☐ 99221
21 ☐ 99222	22 ☐ 99223	23 ☐ 99231	24 ☐ 99232	25 ☐ 99233

Revised Date: ___ / ____ / ____ ☐ Change of Units ☐ Change in Provider ☐ Added Modality ☐ Change in Treatment Date

Treatment Begin Date: ____ / ____ / ____ Treatment End Date: ____ / ____ / ____

Provider Identification Number: _____ Provider Name: _____

Address: _____ City/State: _____

Recommended Duration _____ units/days Client agrees to follow recommendation? ☐ YES ☐ NO

01 ☐ Detox	02 ☐ IP Residential	03 ☐ Halfway House	04 ☐ Partial Hospitalization	05 ☐ Initial OP Interview
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Revised Date: ___ / ____ / ____ ☐ Change of Units ☐ Change in Provider ☐ Added Modality ☐ Change in Treatment Date

Treatment Begin Date: ____ / ____ / ____ Treatment End Date: ____ / ____ / ____

Provider Identification Number: _____ Provider Name: _____

Address: _____ City/State: _____

Recommended Duration _____ units/days Client agrees to follow recommendation? ☐ YES ☐ NO

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Provider Identification Number: _____ Provider Name: _____

Address: _____ City/State: _____

Recommended Duration _____ units/days Client agrees to follow recommendation? ☐ YES ☐ NO

Notwithstanding CDR recommendations, benefits are payable subject to terms, conditions, provisions and limitations of the General Motors Health Care Plan. Any recommended reimbursable interventions not commencing within two weeks of the specified "Treatment Begin Date" are null and void. In this event, the CDR Assessment Coordinator must be contacted for a reassessment of treatment needs.

Did client sign authorization consent form? ☐ YES ☐ NO Date: ____ / ____ / ____

Send completed forms to: ValueOptions, Attn: CareLine, One Towne Square, Suite. 600, Southfield, MI 48076 *CDR FORM 03/22/05*