PLEASE PRINT

Page 1 of 2

HealthChoice and PAC Substance Abuse Notification Form

ALL FIELDS ARE REQUIRED

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 patient.

1. [] Level I: Traditional Outpatient	[]	Level II.1: In] OMT: Methadone Maintenance							
2. MCO Name:	Date Sub	mitted to MCC	Time: "							
3. Client's Name: (Last)			, (Fir	st)						
4. Client's Date of Birth:	5. Client's Go		6. Client's MA Number:			7.Client's MCO Number (if different):				
8. Other Insurer Group # (if applicable):	9. Client's Co	omplete Addre	ss:			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. Reques	sted Start Date	for MCC) Authorization: —	If yes, Du	17. Client 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:										
Tertiary.										
19. Prior Substance Abuse Treatment F	listory - Last 3	3 Years (if know	vn)							
	Tr	eatment Type		Dates of Se	rvice	Trea	atment Status			
19. Prior Substance Abuse Treatment 1	Tr			Dates of Se	rvice	Trez Successful				
19. Prior Substance Abuse Treatment 1	Tr	eatment Type		Dates of Se	rvice					
19. Prior Substance Abuse Treatment 1	Tr	eatment Type		Dates of Se	rvice					
19. Prior Substance Abuse Treatment 1	Tr	eatment Type		Dates of Se	rvice					
19. Prior Substance Abuse Treatment 1	Tr	eatment Type		Dates of Se	rvice					
19. Prior Substance Abuse Treatment 1	Tr (e.g	reatment Type ., OP, IOP, OMT				Successful	Unsuccessful			
19. Prior Substance Abuse Treatment F Name of Treatment Facility 20. List ALL Reported Current Medical	Tr (e.g	reatment Type ., OP, IOP, OMT	ychiatric,		h as: Subox	Successful one & Methado	Unsuccessful			
19. Prior Substance Abuse Treatment F Name of Treatment Facility 20. List ALL Reported Current Medical additional pages if necessary	Tr (e.g	reatment Type ., OP, IOP, OMT	ychiatric,	& Sub. Abuse such	h as: Subox	Successful one & Methado	Unsuccessful One) – Attach			
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HealthChoice Substance Abuse Notification Form								Page 2 of 2				
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						
Dimension I: Withdrawal						0	1	2	3	4		
Dimension II: Biomedical Conditions and Complications						0	1	2	3	4		
Dimension III: Emotional/Behavioral Conditions and Complications						0	1	2	3	4		
Dimension IV: Treatment Acceptance						0	1	2	3	4		
Dimension V: Relapse/Continued Use Potential					0	1	2	3	4			
Dimension VI: Recovery Environment					0	1	2	3	4			
23. Treatment												
	Code	# of Sessions (S) or Units (U) per week (circle one) Sessio						sion/Unit con	on/Unit conversion			
[] Individual	H0004	[] S	or U per w	veek	1 Session = 4 Units (15 minutes per unit)						
[] Group	H0005	[] S	or U per w	veek	1 Session = 1 Unit (60-90 minutes)						
[] Intensive Outpatient	H0015	[] da	ys/week	& [] total 1] total hrs/week Weekly total must be ≥ 9 hrs (Min.2 hrs/day – max. 4 days/wk)							
[] Methadone	H0020		Pe	er week		1 Session = 1 Unit (Must include at least one face to face encounter with counselor)						
24. Anticipated discharge date from this Level of Care (if known)://												
25. Comments – optional 26. Treatment Clinician		se additional p	pages if ne	cessary)								
Printed				Cliniaian Cianat				Creder	atiola	Date		
Printed Clinician Signature								Credei	iuais	Date		
Treatment Clinician's Email Address Treatment Clinician's Phone Numb												