(Please include a copy of the LOCADTR3 Report with this form)

fax: 844-231-7948
email:NYSUDNotifications@carelon.com

Part 822 Services 48 HOUR NOTIFICATION and INITIAL TREATMENT PLAN

Patient Information

Patient Name: _____

Date of Birth: _____/_____/_____

Health Plan: _____

Member ID: _____

☐Commercial ☐Medicaid/Essential

Date of Admission: _____/_____/_____

LOCADTR3 Attached: ☐Yes ☐No

Assessed/Admitted ☐ Assessed/Not Admitted ☐

Provider / Agency Name: _____

Site Address: _____

Case Manager & Phone #: _____

NPI #: _____

Tax ID: _____

Diagnosis: _____

_____

_____

Reason: _____

_____

_____

Initial Treatment Plan

Current Level of Care: _____

Next Anticipated Level of Care: _____

Next Anticipated Service:

- ☐ Additional Assessment
- ☐ OASAS approved detoxification taper / protocol
- ☐ Medication Assisted Treatment
- ☐ Health Assessment and Physical
- ☐ Individual Session
- ☐ Group Session
- ☐ Family / Collateral Sessions
- ☐ Peer Services
- ☐ Toxicology
- ☐ Psychiatric Assessment
- ☐ Other (Please Specify): _____

_____

_____

Signature: _____ Date: _____/_____/_____