PRINT FORM

carelon

Care Treatment Plan Form General Motors
UAW-LLC Employees & Eligible Dependents

FAX TO 248-697-0905

Client Last Name:	**First Name:**	**Member ID#:**
Address:		
Date of Birth: / /		
Case Open Date:	**Primary Diagnosis:**	**Secondary Diagnosis:**
CDR Provider Name:	**CDR Contact PH #**	**Today's Date**

Section A – Detoxification:

Client admitted for detoxification? YES | **NO** | **Admission Date** _____ **Discharge Date** _____

(Specify) **Alcohol** ____ **Specify Other(s)** _____

Provider Name : _____ Tax ID/NPI# _____

Address: _____ City _____ State _____ Zip Code _____

Begin Date: _____ End Date _____ Duration _____ units/days

Section B - Substance Abuse Intervention (HLOC)

Inpatient Substance Abuse Rehabilitation Immediately follows inpatient detox? YES | NO

Provider Name : _____ Tax ID/NPI# _____

Address: _____ City _____ State _____ Zip Code _____

Begin Date: _____ End Date _____ Duration _____ units/days ___ / ___

Partial Rehabilitation Immediately follows inpatient detox or rehab YES | NO

Provider Name : _____ Tax ID/NPI# _____

Address: _____ City _____ State _____ Zip Code _____

Begin Date: _____ End Date _____ Duration _____ units/days

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Residential Immediately follows inpatient detox, or rehab? YE[ ] / NO [ ]

Provider Name : _____ Tax ID/NPI# _____

Address: _____ City _____ State _____ Zip Code _____

Begin Date: _____ End Date _____ Duration _____ units/days

Section C - Substance Abuse Intervention (Other Service Types)

Halfway House _____

Provider Name : _____ Tax ID/NPI# _____

Address: _____ City _____ State _____ Zip Code _____

Begin Date: _____ End Date _____ Duration _____ units/days

Section D - Revisions (Complete all that apply) Use this section to revise a date previously submitted

Original Begin Date: _____ **Original End Date:** _____

New Begin Date: _____ **New End Date:** _____

Units/Days – Old# units: _____ **New # units:** _____ **Type of Treatment From:** _____ **To:** _____

Original Provider: _____ **New provider Info: Name** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____ **Tax ID/NPI#** _____

Benefits are authorized and payable subject to terms, conditions, provisions, benefit availability at the time of the recommendation and limitations of the General Motors LLC Plan.

Client Signature: _____ **Date:** _____

CDR Provider Signature: _____ **Date:** _____