



Part 822 Services 48 HOUR NOTIFICATION and INITIAL TREATMENT PLAN

Patient Information

Patient Name: _____ Provider / Agency Name: _____
Date of Birth: ____ / ____ / ____ Site Address: _____
Health Plan: _____ Case Manager & Phone #: _____
Member ID: _____ NPI #: _____
 Commercial Medicaid/Essential Tax ID: _____
Date of Admission: ____ / ____ / ____ Diagnosis: _____
LOCADTR3 Attached: Yes No _____
Assessed/Admitted Assessed/Not Admitted _____

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: ____ / ____ / ____