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

fax: 844-231-7948
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# 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: ______/______/______