

BEHAVIORAL HEALTHCARE INC.
OUTPATIENT INTEGRATED SERVICE PLAN

Initial Service Plan

Extension of Services

Medication Only Status

Provider/Facility Name: _____ Site Address: _____

Phone: _____ Fax: _____ Email: _____ (unblock email and phone)

Client Name: _____ Date: ____/____/____

DOB: ____/____/____ Medicaid #: _____ CID: Reach Ar Au

DIAGNOSIS	Code:	Description
Axis I Primary:	_____	_____
DSM Criteria:	_____	

Axis I Secondary:	_____	_____
DSM Criteria:	_____	

Axis I Tertiary:	_____	_____
DSM Criteria:	_____	

Axis II:	_____	_____
DSM Criteria:	_____	

Axis III:	_____	_____
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Axis IV:	_____	_____
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Axis V:	_____	_____
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Current Medications:

Prescribing MD: _____

Service Plan: (List problems by priority)

Consumer Strengths and Resources to address problem (s): _____

Problem 1 (describe in functional/behavioral terms): _____

Current Problem Severity: Very High High Medium Low Minimal

Goals (must be written in specific functional/behavioral terms with measurement): _____

Interventions (must be specific and include frequency): _____

Target Date: _____ Responsible Person: _____

Problem 2 (describe in functional/behavioral terms): _____

Current Problem Severity: Very High High Medium Low Minimal

Goals (must be written in specific functional/behavioral terms with measurement): _____

Interventions (must be specific and include frequency): _____

Target Date: _____ Responsible Person: _____

Discharge criteria (specific functional/behavioral criteria):

Case Management Plan:

Purpose: _____

Person/Agency Contacted: _____

Goal: _____

Number and Type of Services Requested

Intake/Assessment by a non-MD	H0031 _____ or 90806	Short term Residential (Non-hospital) Residential Treatment Program, without Room and Board, per day (Includes but not limited to: Initial evaluation, 1 Individual session per week, 2 group therapy per week, 1 Family therapy per week, weekly case management, and monthly psychiatrist sessions as needed)	H0018-SC _____	
Individual psychotherapy, 20-30 minutes, face-to-face with the patient	90804 _____			
Individual psychotherapy, 45-60 minutes, face-to-face, with the patient	90806 _____			
Interactive (play therapy), 45-50 minutes, with the patient	90812 _____		Short term Residential Acute Treatment	H0018-AT _____
Family therapy without patient present, 45-50 minutes	90846 _____		Long Term Residential, (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per day. (Includes, but not limited to: initial evaluation, weekly individual, 2 groups per week, weekly family therapy, weekly case management, and monthly Psychiatrist sessions as needed.)	H0019-SC _____
Family Therapy with patient present, 45-50 minutes	90847 _____		Other: please describe	Code: _____
Group psychotherapy	90853 _____		_____	_____
Psychiatric diagnostic Interview, by psychiatrist	90801 _____		_____	_____
Individual therapy with medical evaluation and management services, with patient, 20-30 minutes	90805 _____		_____	_____
Medication Management	90862 _____		_____	_____
Day Treatment, per hour	H2012 _____	Provider Signature	Date	
Case Management, per 15 minutes, 30 minute max or as contracted	T1016 _____			

Consumer Comments: _____

Consumer Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

BHI/ MHC ONLY

I have reviewed the above service plan (and if necessary, other documents needed to ensure that the treatment meets criteria for medical necessity) and find that the treatment recommended is medically necessary.

Physician's Signature

Date

BHI Receipt Date: _____ Received By: _____

MHC Receipt Date: _____ Received By: _____

Approved as Requested Approved with Modification Denied

Date Action letter sent: _____