Coordination of Care Treatment Plan

Welcome to the Behavioral Health Coordination of Care Treatment Plan. Access to the complete form will be granted upon completion of the Authorization Information section. Please Enter a valid IEHP ID, authorization number, select a Behavioral Health Service Provider and select a Request for Additional Services option.

* denotes a required field

Request Information

*IEHP ID:	IEHPID
*Authorization Number	
*Requesting Provider	
*Request For Additional Services	Continue with Medication Management
Next Scheduled Visit Date (if applicable)	MM/DD/YYYY

Member Information

Name:	Gender:	DOB:	Age:
Address:	City:	State-Zip:	Phone:
IEHP ID:	CIN:	MediCare:	Medi-Cal:
LOB:	County:	Aid Code:	Group:

Member PCP Information

Name:	ID:	NPI #:	Phone:
Address:	City:	State-Zip:	Fax #:

Requesting Provider Information

Name:	ID:	NPI #:	Phone:
Address:	City:	State-Zip:	Fax #:
Request Date:	Provider Signature:		

Diagnosis

*Primary Diagnosis	Search Primary Diagnosis ICD
*Secondary Diagnosis	Search Secondary Diagnosis ICD
Additional Diagnosis	Search Additional Diagnosis ICD
Physical Disorders and/or Medical Conditions	Search Disorders/Conditions ICD

Current Medication

*Is the Member currently taking mental health medication NOT listed below? Yes | No

*Drug Name | *Dosage Form | *Strength (mg/ml) | *Quantity

Add Medication +

Pharmacy Information (Past 6 Months)

Drug Name	Prescriber	Filled By	Qty	Filled On

« Prev | 1 | 2 | Next »

Unfilled Prescriptions (Past 1 Month)

No Records Found (1 month prior)

CPT Codes

*CPT 1: | Modifier: | *Qty:(numeric only)

Add +

Visit Information

IEHP strongly encourages communication between treating specialists and referring Providers, to support coordination and integration of care efforts for our Members. Therefore, we request that a Release of Information be signed by our Member and included with this form, which will allow the information contained on this form to be shared securely with the designated provider through IEHP's Provider Portal.

Last Known Member Phone # (e.g. 9991234567): Phone Number (ie. 9991234567)

*Verified Member signed the required Release of Information Form allowing IEHP to release medical and behavioral health information to PCP or Referring Provider. Yes | No

Please attach completed Release of Information form in the Supporting Documents section below. Click here to print the release.

*Discussed referral with Member who is in agreement. ☐

*Co Treating BH Provider Other Than Self: Yes | No

Search Available BH Providers

*Have you addressed clinical concerns with other BH Providers for this Member? Select One

*Have you been in communication with the Member's prescriber of psychotropic medication? Select One

*Have you communicated medical concerns with Members primary care doctor(s)? Select One

Tier 3 Screening

The following questions are intended to identify Members who need to be transitioned to a County Mental Health System for a higher level of care and/or Member meets Tier 3 Criteria

*Does the Member have any of the following conditions?

- [x] Pervasive Development Disorder, except Autism Disorder
- [ ] Feeding and Eating Disorders of Infancy and Early Childhood
- [ ] Other Disorders of Infancy, Childhood or Adolescence
- [ ] Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
- [ ] Faciticious Disorders
- [ ] Paraphailias
- [ ] Eating Disorders
- [ ] Adjustment Disorders
- [ ] Medication-Induced Movement Disorders related to other included diagnosis
- [ ] Disruptive Behavior and Attention Deficit Disorders
- [ ] Elimination Disorder
- [ ] Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to General Medical Condition
- [ ] Somatoform Disorders
- [ ] Dissociative Disorders
- [ ] Gender Identity Disorders
- [ ] Impulse Control Disorders not Elsewhere Classified
- [ ] Personality Disorders, excluding Antisocial Personality Disorder
- [ ] None

*As a result of a mental disorder, does the Member have a significant impairment in any of the following life functioning areas?

- [x] Health / Self-Care / Housing
- [ ] Legal
- [ ] Interpersonal / Social
- [ ] Occupational and Academic
- [ ] Financial
- [ ] None

*Will the focus of the proposed intervention/treatment be to accomplish one or more of the following:

- [x] Significantly diminish the impairment
- [ ] Allow the child to progress developmentally as individually appropriate
- [ ] Prevent significant deterioration in an important area of life functioning
- [ ] None

* The mental disorder would not be responsive to primary care based treatment. Yes **No**

Treatment Objectives

Please indicate the 3 continued or future treatment objectives

*Objective 1:

*Treatment Modality

- [ ] CBT
- [ ] Behavior Modification
- [ ] Solution-Focused Therapy
- [ ] Eclectic Therapy
- [ ] Patient Centered
- [ ] DBT
- [ ] Psychodynamic
- [ ] Supportive Care
- [ ] Exposure and Response Prevention
- [ ] EMDR
- [ ] Seeking Safety
- [x] Other

Please Specify

*Current Rating: 4 - Some Improvement

*Prior Rating: Select One

*Objective 2:

*Treatment Modality

- [ ] CBT
- [ ] Behavior Modification
- [ ] Solution-Focused Therapy
- [ ] Eclectic Therapy
- [ ] Patient Centered
- [ ] DBT
- [ ] Psychodynamic
- [ ] Supportive Care
- [ ] Exposure and Response Prevention
- [ ] EMDR
- [ ] Seeking Safety
- [ ] Other

*Current Rating: Select One

Objective 3:

Treatment Modality

- [ ] CBT
- [ ] Behavior Modification
- [ ] Solution-Focused Therapy
- [ ] Eclectic Therapy
- [ ] Patient Centered
- [ ] DBT
- [ ] Psychodynamic
- [ ] Supportive Care
- [ ] Exposure and Response Prevention
- [ ] EMDR
- [ ] Seeking Safety
- [ ] Other

Current Rating: Select One

*Has the Member received treatment in a higher level of care (e.g. Inpatient Psychiatric Hospitalization, Intensive Outpatient Treatment) in the last 6 months? Yes / No

*Was a standard instrument used to evaluate treatment progress? Yes / No

Name of the instrument

Additional Clinical Information

Special Instructions / Comments

Attach Supporting Documents

Up to 8 PDF or Word files, 10 MB per file maximum size

Note: Dragging and dropping files into browser window may navigate away from page

Filename	Size	Status
Add Files	0 b	0%

Submit Cancel