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	No Further Treatment Requested
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

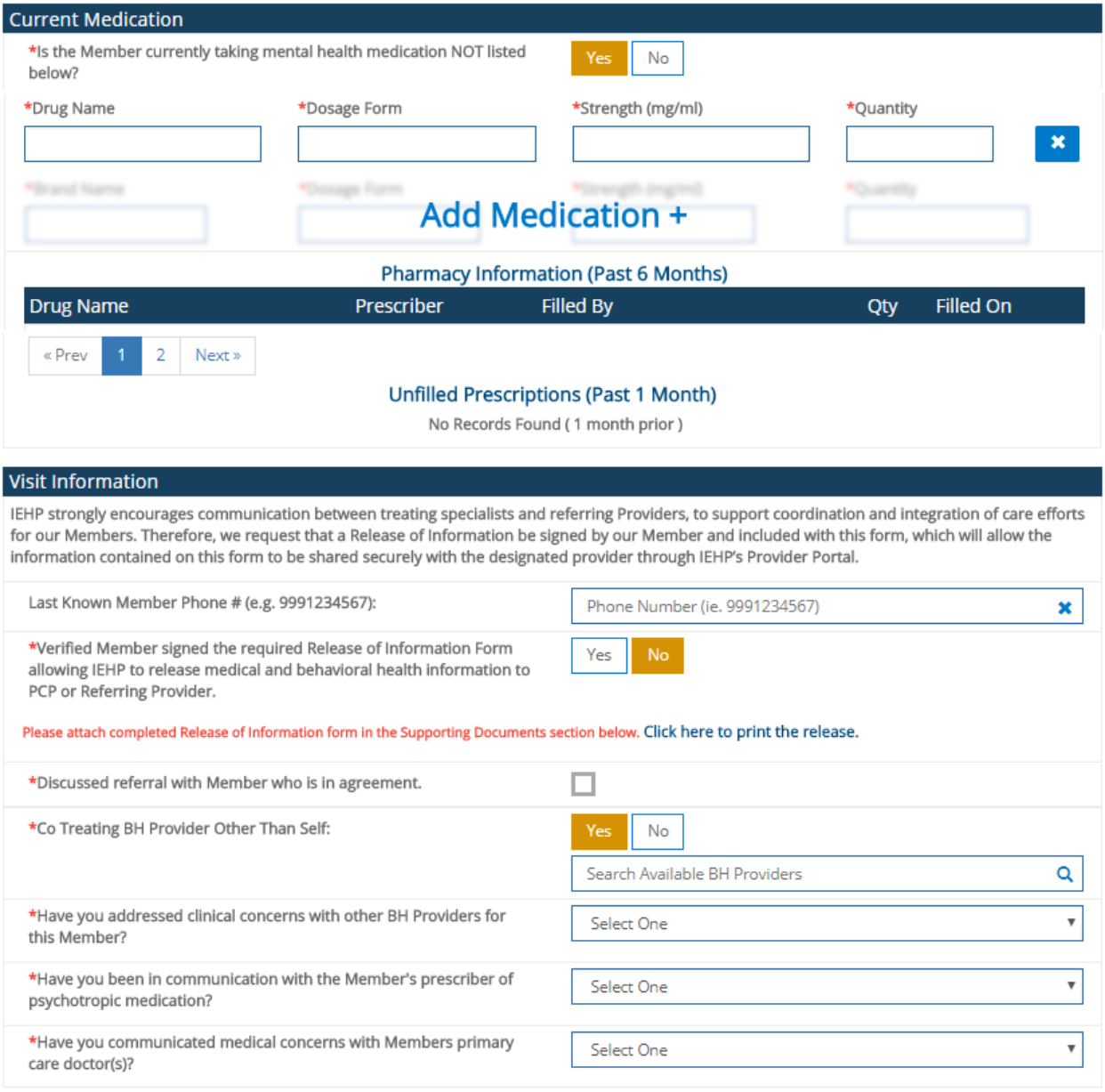
Name:	ID:	NPI #:	Phone:
Address:	City:	State-Zip:	Fax #:

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



Note: Different expanded options for After Care Plan

After Care Plan (Select ONE from below)

- ○ Provider Referred Stable Member Back to PCP for Ongoing Psychotropic Medication Management
- ○ Provider Referred Member to Community Resources or Self Help Groups for Ongoing Support
- ◉ Member Discontinued Treatment (Please indicate why)
  - ◉ Member Dropped Out — # of Sessions Attended
  - ○ Member Relocated
  - ○ Member Expressed No Interest in Treatment
  - ○ Other
- ○ Provider Referred Member to Higher Level of Care
- ○ Treatment Completed

After Care Plan (Select ONE from below)

- ○ Provider Referred Stable Member Back to PCP for Ongoing Psychotropic Medication Management
- ○ Provider Referred Member to Community Resources or Self Help Groups for Ongoing Support
- ○ Member Discontinued Treatment (Please indicate why)
- ◉ Provider Referred Member to Higher Level of Care
  - ○ County Mental Health Program
  - ◉ Other — Please Specify
- ○ Treatment Completed

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