meridianhealth
A WellCare Company
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CONTINUED OUTPATIENT TREATMENT NOTIFICATION FORM (COTNF)

Complete the form and fax it to the member's PCP and MeridianHealth (Meridian) by the member's **3rd visit**. *It is important to provide communication with the PCP when there are changes in the treatment plan and/or medication.*

THIS IS A 2-SIDED FORM

Member Information

Member Name_____

Member ID_____ D.O.B._____

Date of Initial Visit _____ # of Visits Used ____

DSM-5 Diagnosis *(use only ICD-10-CM codes):*

_____ _____ _____

_____ _____ _____

Please check the member's co-morbid medical conditions:

☐None ☐Asthma/COPD ☐Cancer

☐Cardiovascular Problems ☐Chronic Pain

☐Dementia ☐Diabetes

Other_____

Treatment

___ Individual: Billing Code: _____

visits needed_____ How often _____

___Family: Billing Code: _____

visits needed_____ How often _____

___Group Therapy: Billing Code: _____

Type of Group: _____

visits needed_____ How often _____

___Medication Management: Billing Code: _____

visits needed_____ How often _____

___Other: Please explain _____

Billing Codes: _____

visits needed_____ How often _____

Psychological/Neuropsychological Testing:

Was testing completed? ☐ Yes ☐ No

If so, when? _____

Treatment Plan

Member participated in treatment plan development?

☐ Yes ☐ No ☐ Member refused participation

Treatment Plan has been discussed with the member?

☐ Yes ☐ No

If not, why?_____

Member agrees with the treatment plan? ☐Yes ☐No

Behavioral Health Provider Information

Agency Name _____

Practitioner Name _____

Credentials _____

Phone _____ Fax _____

Primary Care Provider (PCP) Information

PCP Name _____

Phone _____ Fax _____

When a member is discharged from services, please fax a copy of the discharge plan along with this form to MeridianHealth's Behavioral Health department at 313-202-1268.

Please complete page 2!

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Primary Care Provider (PCP) Coordination

Has the PCP been notified of the member being in treatment, including medication?

☐ Yes ☐ No ☐ Member refused permission

☐ Client refuses due to active symptoms

☐ Client refuses due to expressed concerns over privacy

☐ Guardian does not want information shared with PCP

☐ Client will not share reason

☐ Legal issues (ex. Court case that the client does not want medical records released to any other party)

Has the member been prescribed medication by their PCP? ☐ Yes ☐ No

Prescribing physician(s) _____

Medications & dosages

_____

_____

_____

Medication(s) Prescribed by a Psychiatrist

☐ Yes ☐ No

Medications & dosages Date

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Discharge Plan

Expected Discharge Date _____

Will the member be participating in aftercare groups and/or self-help groups?

☐ Yes ☐ No Type _____

Does the member have social/family support? ☐ Yes ☐ No

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