

RTN

Psychiatric Services Treatment Plan Form for Provider Type 36 Community Mental Health Services



799 Roosevelt Rd,
Bldg 4, Suite 200
Glen Ellyn, Illinois 60137
(866) 503-9040 Toll Free
(630) 873-1450 Fax

THIS FORM MUST BE SIGNED BY THE LPHA. AN ILLEGIBLE, INCOMPLETE, INACCURATE, OR CONFLICTING TREATMENT PLAN MAY CAUSE THE PARTICIPANT'S TRANSPORTATION REQUEST TO BE DENIED.

NON-EMERGENCY TRANSPORTATION (NET) PROVIDERS ARE NOT ALLOWED TO COMPLETE OR SUBMIT THIS FORM.

Section One

Participant Name <input style="width: 90%;" type="text"/>	Recipient Identification Number <input style="width: 90%;" type="text"/>
Pickup Address <input style="width: 90%;" type="text"/>	City <input style="width: 15%;" type="text"/> State <input style="width: 10%;" type="text"/> Zip <input style="width: 15%;" type="text"/>
Start Date <input style="width: 15%;" type="text"/>	End Date <input style="width: 15%;" type="text"/> Appointment Time <input style="width: 20%;" type="text"/>

Section Two

Transportation Provider <input style="width: 90%;" type="text"/>	Phone <input style="width: 90%;" type="text"/>
Most appropriate/least expensive mode of transport <input style="width: 90%;" type="text"/>	Attendants <input style="width: 90%;" type="text"/>

Section Three

Is there a current ITP or MHA? Yes No ITP or MHA Date

DSM-IV-TR Diagnosis - Axis I

Transportation services are not covered for vocational training or on dates where Medicaid services are not reimbursed.
Please refer to the Community Mental Health Services Definitions and Reimbursement Guide.

Appointment Day	Specify Group (A, B, C or D)	HCPCS Codes
<input type="checkbox"/> Monday	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
<input type="checkbox"/> Tuesday	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
<input type="checkbox"/> Wednesday	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
<input type="checkbox"/> Thursday	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
<input type="checkbox"/> Friday	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
<input type="checkbox"/> Saturday	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
<input type="checkbox"/> Sunday	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Section Four

Facility Name <input style="width: 90%;" type="text"/>	Phone Number <input style="width: 90%;" type="text"/>
Facility Address <input style="width: 95%;" type="text"/>	
LPHA Name <input style="width: 90%;" type="text"/>	Provider ID # <input style="width: 90%;" type="text"/>
LPHA Phone Number to Validate Treatment Plan <input style="width: 90%;" type="text"/>	Site Number <input style="width: 90%;" type="text"/>

Agreement and Signature: I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify, under penalty of perjury, the information provided is accurate and concurs with the Clinical Record to the best of my knowledge and I will notify First Transit of any changes in the information set forth above as I become aware of such changes.

LPHA Signature <input style="width: 90%;" type="text"/>	Date Signed <input style="width: 90%;" type="text"/>
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