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PLEASE VISIT
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to download copies of the Psychiatric Services Treatment Plan Form

Psychiatric Services Treatment Plan Form for CAP/GAP Providers

DEVELOPED BASED ON GROUP PSYCHOTHERAPY ADMINISTRATION RULES 89 IL ADMIN CODE 140.413 (a) (4)

THIS FORM MUST BE SIGNED BY THE REFERRING AND DIRECT SERVICE PROVIDER'S ORIGINAL SIGNATURE. 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.

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

Section One

Participant Name: _____ Identification Number (RIN): _____
(Last) (First)

Section Two

Behavioral Health Services - Referring Physician Information

Physician's Name: _____ Provider ID #: _____
(Last) (First)

Date(s) of Service: _____ Most Direct Phone Number to Validate Information: _____

Mental Illness Diagnosis or ICD-9-CM and Description: _____

Nature of the medical need, the necessity for on-going visits and the expected duration of on-going visits:

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, that the information provided is accurate to the best of my knowledge, that I will notify First Transit of any changes in the information set forth above when I become aware of such changes, and **that I am NOT a Non-Emergency Transportation (NET) Provider**. Additionally, I understand that the referral must be to the closest medical provider available to perform these services in order to meet the necessary NETSPAP criteria.

Referring Physician's Signature: _____ Date Signed: _____

Section Three

Behavioral Health Services - Direct Service Provider

Facility Name: _____ Phone Number: _____

Facility Address: _____

Direct Service Provider Name: _____ Provider ID #: _____
(Last) (First)

Direct Service Provider Phone Number to Validate Treatment Plan: _____ Initial Evaluation Date: _____

Dates of Service: _____ Total Number of Sessions: _____ Treatment Time Frame per Session: _____

Treatment Plan and Goals:

When you bill the payor, what services do you bill? _____

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, that the information provided is accurate to the best of my knowledge, that I will notify First Transit of any changes in the information set forth above when I become aware of such changes, and **that I am NOT a Non-Emergency Transportation (NET) Provider**. I understand that group psychotherapy services must be directly performed by a physician licensed to practice medicine in all its branches who has completed an approved general psychiatry residency program or is providing that service as a resident or attending physician at an approved or accredited residency program; and the group size does not exceed 12 patients, regardless of payment source. Additionally, I understand that if the patient is a resident of a long-term care facility, the provider of the group psychotherapy must maintain documentation in the patient's medical record demonstrating coordination of services and the sharing with the long-term care facility of information related to the patient's needs and the implementation and effectiveness of the patient's plan of care.

Direct Service Provider Signature: _____ Date Signed: _____