

## Continuing Care Treatment Plan Form

Demographics																										
CDR Number: _____ Primary Enrollee Last Name: _____ First Name: _____	Revised? <input type="checkbox"/> YES <input type="checkbox"/> NO Contract Number: _____																									
Client Last Name: _____ First Name: _____ Date of Birth: ____ / ____ / ____																										
Case Open Date: ____ / ____ / ____	Primary Diagnosis: _____ Secondary Diagnosis: _____																									
Section A – Detoxification																										
Client admitted for detoxification? <input type="checkbox"/> YES <input type="checkbox"/> NO	Was an extension beyond 72 hours requested and approved? <input type="checkbox"/> YES <input type="checkbox"/> NO																									
Section B - Reimbursable Substance Abuse Intervention (please ✓ one only per section)																										
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<i>Notwithstanding CDR recommendations, benefits are payable subject to terms, conditions, provisions and limitations of the General Motors Health Care Plan. Any recommended reimbursable interventions not commencing within two weeks of the specified "Treatment Begin Date" are null and void. In this event, the CDR Assessment Coordinator must be contacted for a reassessment of treatment needs.</i>																										
Did client sign authorization consent form? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date: ____ / ____ / ____																									