



Continuing Care Treatment Plan Form
 General Motors LLC Employees & Eligible Dependents

FAX TO VO AT 248-697-0908

Client Last Name: _____	First Name: _____	Member ID#: _____
Address: _____		
Date of Birth: / /		
Case Open Date: _____	Primary Diagnosis: _____	Secondary Diagnosis: _____
CDR Provider Name: _____	CDR Contact PH # _____	Today's Date _____

Section A – Detoxification:
 Client admitted for detoxification? YES ___ / NO ___ **Admission Date** _____ **Discharge Date** _____
 (Specify) **Alcohol** ___ **Specify Other(s)** _____

Section B - Substance Abuse Intervention (HLOC)

Inpatient Substance Abuse Rehabilitation Immediately follows inpatient detox? YES ___ /NO ___
 Provider Name : _____ **Tax ID/NPI#** _____
Address: _____ **City** _____ **State** _____ **Zip Code** _____
 Begin Date: _____ End Date _____ Duration _____ units/days

Partial Rehabilitation Immediately follows inpatient detox or rehab YES ___ / NO ___
 Provider Name : _____ **Tax ID/NPI#** _____
Address: _____ **City** _____ **State** _____ **Zip Code** _____
 Begin Date: _____ End Date _____ Duration _____ units/days

Section C - Substance Abuse Intervention (Outpatient Level)

Intensive Outpatient Immediately follows inpatient detox, rehab or partial hospitalization? YES ___ / NO ___
 Provider Name : _____ **Tax ID/NPI#** _____
Address: _____ **City** _____ **State** _____ **Zip Code** _____
 Begin Date: _____ End Date _____ Duration _____ units/days

Outpatient Immediately follows inpatient detox, rehab or partial hospitalization? YES ___ / NO ___
 Provider Name : _____ **Tax ID/NPI#** _____
Address: _____ **City** _____ **State** _____ **Zip Code** _____
 Begin Date: _____ End Date _____ Duration _____ units/days

Section D - Substance Abuse Intervention (Other Service Types)

Halfway House _____ **15 Min OP Cons** _____ **30 Min OP Cons** _____ **40 Min OP Cons** _____ **60 Min OP Cons** _____ **80 Min OP Cons** _____ **THC** _____
Residential _____ **Emergency Room** _____ **Provider Sanction** _____
 Provider Name : _____ **Tax ID/NPI#** _____
Address: _____ **City** _____ **State** _____ **Zip Code** _____
 Begin Date: _____ End Date _____ Duration _____ units/days

Section E - Revisions (Complete all that apply)

Begin Date - Old Begin: _____ **New Begin:** _____ **End Date - Old End:** _____ **New End:** _____
Units/Days – Old# units: _____ **New # units:** _____ **Type of Treatment From:** _____ **To:** _____
Original Provider: _____ **New provider Info: Name** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____ **Tax ID/NPI#** _____

Benefits are authorized and payable subject to terms, conditions, provisions, benefit availability at the time of the recommendation and limitations of the General Motors LLC Plan. Failure to follow any recommended level of care will constitute treatment non-compliance according to Appendix B II C of the Supplemental Agreement. **The focus of the substance abuse treatment coverage is to assist employees (and their dependents) in recovering. Toward this end, if an employee discontinues his/her treatment plan, there will be a warning issued for the first occurrence. For occurrences thereafter, up to \$1,000 may be recovered.** Such overpayments will be recovered from the employee through cash payments or deductions from wages, or deductions from non-pension wage replacement benefits. My signature reflects that I have been fully aware of the sanction process.
 Client agrees to follow recommended level of care? YES ___ / NO ___

Client Signature: _____ **Date:** _____
CDR Provider Signature: _____ **Date:** _____