MH 653 NCR
Revised 12/11/12

COMPLEX MEDICATION SUPPORT SERVICE

(To be used by MD/DO and NP and students of these disciplines)

For use with clients not yet stable on medication which requires detailed history, assessment and decision-making for prescribing medication.

To meet all payor documentation standards, the note must include detailed information for **BOLDED** elements:

Chief Complaint/Presenting Problem/Client Goals:

History (Family and Social) [Include any changes or additions to the Initial Assessment or Initial Medication Support Service (MH 657)]:

Treatment Response/Medication Side Effects:

Adherence to Medication:

Name: **IS#:**

Agency: **Provider #:**

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Current/Changes in Medical Status:

Mental Status:

Assessment/Clinical Impression:

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Diagnosis: ☐ **Diagnosis remains the same** ☐ **Diagnosis changed [complete Diagnosis Information Form (MH 501)]**

Intervention/Plan/Clinical Decision Making/Counseling/Recommended Consultations (Include explanation of changes in Plan and/or Medication):

Laboratory Tests Ordered: ☐ **CBC** ☐ **LFT** ☐ **Electrolytes** ☐ **Lipids** ☐ **Glucose** ☐ **HgbA1C**
☐ **Tox Screen** ☐ **Med Levels** ☐ **TFTs** ☐ **Other/Details:** _____

Medication(s) Prescribed: **The Outpatient Medication Review Form (MH556) must be completed by the MD/DO/NP annually and any time a new medication is prescribed or resumed following a documented withdrawal of the medication.**

Name	Dosage	Frequency	Route of Administration	Amount	# of Refills

☐ **Provided through the use of Telemental Health services. Client signed the Consent for Telemental Health Services and concerns were**

☐ **Continued** (Sign & complete information on **Medication Note Addendum**)

By signing my name below, I attest that I have provided the mental health services recorded on this NCR note form and that all information is accurate, complete & truthful to the best of my knowledge. I further attest that the services provided by me, as reflected on this NCR Note form, were consistent with the client's treatment plan, and, if services are to be claimed to Medicare and/or Medi-Cal, were reasonable and medically necessary. Claim for services submitted as a result of this NCR Note form are supported by documentation.

Service is Medi-Cal Claimable (Check One): **Y**☐ **N**☐

_____ _____ _____ _____
Signature & Discipline | Date | Co-Signature & Discipline | Date

Date of Service: **Procedure Code:** Office Visit ☐ New** Client 99203 ☐ Established Client 99213
Home Visit ☐ New** Client 99343 ☐ Established Client 99349

**New Client is a client who has not been seen at this Billing Provider/Reporting Unit by an MD/DO/NP within the past three years

Place of Service: **Plan:**

1. Address:

Evidenced Based Practice (EBP) Service Strategy (SS) (See IS Codes Manual for a listing of Codes): _____ _____ _____

Rendering Provider Name: **Staff Code:** ***Face-to-Face/Other Time (Hrs:Mins):**

Client Present: ☐ **Y** ☐ **N** **# Collaterals:** **Relationship(s):** ***All travel and documentation time must be recorded as "**Other Time**".

2. EPSDT Screening Referral: ☐ Y ☐ N **3. Pregnancy:** ☐ Y ☐ N **4. Emergency:** ☐ Y ☐ N **5. SED:** ☐ Y ☐ N **6. Share of Cost:** ☐ Y ☐ N

(FOR SUPPORT STAFF ONLY) Data Entry Initials:

Medi-Cal: Y☐ N☐ **Medi-Cal Late Code:** A☐ B☐ C☐ **Medicare:** Y☐ N☐ **Crossover Code:** X☐ B☐ P☐ H☐ N☐ E☐

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_____	_____	_____	_____

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File Original in Clinical Record
Copy of Claim to Data Entry

COMPLEX MEDICATION SUPPORT SERVICE