MH 655 NCR
Revised 12/11/12

BRIEF FOLLOW-UP MEDICATION SUPPORT SERVICE

(For use by MD/DO and NP and students of these disciplines)

For use when prescribing medications with clients stable on medication or when prescribing medications based on a phone call or collateral contact.

Chief Complaint/Client Goals:

Brief History of Present Illness/Problem:

Treatment Response/Medication Side Effects:

Adherence to Medication:

Mental Status:

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

Assessment/Intervention/Plan/Clinical Decision Making (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 annually or when new/resumed meds prescribed.**

Name	Dosage	Frequency	Route of Admin	Amount	# of Refills

☐ Continued **(Sign & complete information on** Medication Note Addendum**)** ☐ **Telemental Health Services provided; Consent for Telemental Health Services signed**

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: Yes No

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

Date of Service: **Procedure Code:** ☐ Office Visit 99212 ☐ Home Visit 99347 ☐ H2010 (telephone refill)

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 ☐

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

File Original in Clinical Record
Copy of Claim to Data Entry

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