MH 656 NCR
Revised 03/31/11

# NON-PRESCRIPTION MEDICATION NOTE

(For use by MD/DO, NP, RN, PT, LVN, and students of these disciplines)

☐ Continued **(Sign & complete information on last page of Non-Prescription Medication Note)**

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:** **Place of Service:** **Procedure Code:** ☐ **H2010 – Complex Med** ☐ **H0033 – Oral Admin** ☐ **96372 - Injection**

**Telephone:** ☐ Yes ☐ No **Collateral:** ☐ Yes ☐ No **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):**

**Staff Name:** **Total Activity Time* (Hrs:Mins):** **Staff Name:** **Total Activity 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**

**This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.**

**Name:** **IS#:**

**Agency:** **Provider #:**

**Los Angeles County – Department of Mental Health**

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