Seeking Change Counseling
Raleigh, NC

Order for Medical Necessity

Client Name**:** _____ DOB: _____
Medical Record #: _____ Medicaid #: _____

DIRECTIONS: COMPLETE THE EFFECTIVE DATE AND SIGNATURE LINE FOR EACH SERVICE ORDERED, EFFECTIVE DATE SHOULD BE THE DATE THE SERVICE WAS DETERMINED NECESSARY.

The services indicated below have been determined to be medically necessary for the client named above. This order for service does not indicate supervision of service provided or that the MD or Psychologist has any role other than in determining medical necessity unless other role is specified elsewhere (e.g. treating psychiatrist).

SERVICE ORDERED	DATE OF ORDER	PRINT NAME OR STAMP	SIGNATURE OF MD, PhD, NP OR PA *(do not use stamps)*
****Behavioral Health Outpatient**- (shall be reviewed annually)			
Community Support-Adults			
Community Support –Child/ Adolescents			
Community Support Team			
DD Targeted Case Management			
Mobile Crisis Management Intensive In-Home Multisystemic Therapy			
Assertive Community Treatment Team			
Psychosocial Rehabilitation			
Child & Adolescent Day Treatment			
Partial Hospitalization			
Facility Based Court-Ordered by PCP, Psychiatrist or Licensed Psychologist			
SA Intensive Outpatient Program			
SA Comprehensive Outpatient Treatment Program			
Arc Inpatient			
SA Non-Medical Community Residential Treatment SA Medically Monitored Community Residential Treatment			
Ambulatory Detoxification			
Social Setting Detoxification Non-Hospital Medical Detoxification			
Medically Supervised or ADATC Detoxification/Crisis Stabilization			
Opioid Treatment			
Residential Treatment Level I			
Residential Treatment Level II			