

# PART 822-4 CHEMICAL DEPENDENCE OUTPATIENT SERVICES UTILIZATION REVIEW (UR) FORM

PATIENT NAME:	ID #:	ADMISSION DATE:
CHECK ONE: <input type="checkbox"/> PRIMARY <input type="checkbox"/> SIGNIFICANT OTHER	DATE OF THIS UR:	

RETENTION
<p>Does the patient continue to meet retention criteria for continued stay? <i>(If No, please explain):</i> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>
<p>Summary of Effectiveness and Progress in Treatment:</p>
<p>Is there documentation to establish continuing progress toward goals in applicable functional areas? <i>(If No, please explain):</i> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>
<p>Are services identified in treatment plan appropriate to patient needs? <i>(If No, please explain):</i> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>
<p>If modification is indicated, has plan been modified? <i>(If No, please explain):</i> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>
<p>Are additional services necessary? <i>(If Yes, describe needed services):</i> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>
<p>Recommendation Summary regarding continued stay, intensity of service and/or referral:</p>

Quality Improvement Commentary :

Adverse Determination Commentary :

**QHP COMPLETING UTILIZATION REVIEW**  
**(Per provider policy -- include name, title, signature and date)**

NAME of Qualified Health Professional

TITLE

SIGNATURE

DATE