Two-Day Notification and Initial Treatment Plan

Inpatient Psychiatric Hospitals should complete this form to notify MVP Health Care® (MVP) when a child age 17 and under is admitted for inpatient mental health treatment.

Refer to the guidance memorandum issued by the New York State Office of Mental Health, *Prohibition Against Preauthorization and Concurrent Review During First 14 Days of an Inpatient Admission for a Mental Health Condition for Individuals Under 18*, released December 30, 2019. The memorandum is available by visiting **omh.ny.gov/omhweb/bho/parity.html**.

Please submit this completed Request to MVP by: Email **bhservices@mvphealthcare.com** Fax **1-855-853-4850**

Section 1: MVP Member Information

Member Name	Date of Birth	MVP Member ID No.

Member's Legal Guardian Name	Phone No.

Admitting Hospital	Date of Admission

Hospital Street Address	City	State	Zip Code

Hospital Tax ID No.	**Hospital** NPI No.

Section 2: Diagnoses Details

Mental Heath Diagnoses

Co-occurring Substance Use Disorder Diagnoses

☐ **Tobacco, or Other Nicotine Use Disorder**

Medical Diagoses

Chief Complaint

Medical and/or Substance Use Disorder Problems in Need of Acute Stabilization *(if applicable)*

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MVP Member Name	**MVP Member ID No.**

Section 3: Initial Treatment Plan(s)

Medications

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Psychotherapy *(select all that apply)* ☐ Individual ☐ Family ☐ Group

Consultation *(if applicable)*

Coordination of Care with Other Providers

Preliminary Discharge Plan

Treatment for Substance Use Disorder *(if applicable)*

☐ Nicotine Replacement Therapy ☐ Naloxone ☐ Buprenorphine ☐ Other: ____________________

Assigned Clinician(s) to Coordinate with Plan	Phone No.

Clinician Name (print) *Title*

Clinician Signature *Date*