Community Health, Inc.
Synthetic Opiate Treatment Services
Change in Client Status Information Form

Oregon Health Plan

Agency Name		
Date		
Client Name: Last	First	M.I.
Health Plan		
ODS ID#		
Client terminated from program	Date of last service	

Reason for termination:

- ☐ Client left AMA
- ☐ Client transferred to another clinic site with the same agency
- ☐ Client transferred to another synthetic opiate treatment program
- ☐ Phase level and beginning date of phase level at time of transfer
- ☐ Completed treatment
- ☐ Client incarcerated
- ☐ Client in non-compliance
- ☐ Client completed detoxification

Name of program client transferred to

Has this agency been communicated with? ☐ Yes ☐ No

If no, please explain

Client's stated reason for transferring

Client changed health plan

From _____ (name of plan - include last day of coverage)

To _____ (name of plan - include first day of coverage)

Change in Phase Level

(If detoxification client, enter length of detoxification in beginning phase space)

From Phase _____ To Phase _____

Date of Phase Level change

Comments

Benefits are based on current eligibility at the time the authorization was submitted. Before providing services, provider shall verify member eligibility by telephone.

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