PROJECT BRAVO
BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

ARTS Addiction and Recovery Treatment Services

VIRGINIA'S MEDICAID PROGRAM DMAS

The Department of Medical Assistance Services

ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS) AND MENTAL HEALTH SERVICES (MHS) REGISTRATION FORM

The information on this form must be submitted to the member's plan. **Each requested service must be submitted separately. Multiple services cannot be registered on the same form.**

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		**Organization Name:**	
Member Last Name:		**Group NPI #:**	
Medicaid #:		**Provider Tax ID #:**	
Member Date of Birth:		**Provider Phone #:**	
Gender:		**Provider E-Mail:**	
Member Plan ID #:		**Provider Address:**	
Member Address:		**City, State, ZIP:**	
City, State, ZIP:		**Provider Fax #:**	
Member Phone #:		**Clinical Contact Name & Credentials*:**	
Parent/Guardian Name (if applicable):		**Clinical Contact Phone #:**	
Parent/Guardian Phone # (if applicable):			

* *This is the individual to whom the Health Plan can reach out to answer additional clinical questions.*

CRISIS CALL CENTER INFORMATION (Mobile Crisis Response/Community Stabilization Only)	
Call Center Reference #:	

SERVICE INFORMATION (Time of admission is only required for Crisis Services)							
Requested Service:							
Requested Start Date		**Time of Admission:**		**Requested End Date:**		**Requested Units:**	

CLINICAL INFORMATION	
Primary Diagnosis:	
Secondary Diagnosis:	

ADDITIONAL INFORMATION

If requesting Mental Health Case Management or Substance Use Case Management for an individual that is (or will be) participating in Assertive Community Treatment (H0040), please provide the following:

1. **Evidence of how the provision of both services will not be a duplication of service.**
2. **Identify treatment goals for the case management services and how these goals will be different from the goals for Assertive Community Treatment.**
3. **Evidence that the individual participating in the service has been provided education on case management services and the service components of Assertive Community Treatment and the individual is requesting separate case management service.**

Member Name: Medicaid #: