

## Involuntary Treatment Act Patient Claim Information

### PURPOSE

The Involuntary Treatment Act Patient Claim Information form supplies demographic information necessary for the creation of ITA related eligibility when a person without active medical assistance is involuntarily detained under 71.05.

### FORM DISTRIBUTION

This form may be completed by the service provider, however, proof of ITA status consistent with Mental Proceeding Rule 2.2/22A is also necessary for Client ID and/or Eligibility Segment creation.

NAME (LAST, FIRST, MIDDLE INITIAL)		PROVIDER ONE CLIENT ID (If Available)	
ADDRESS		CITY	STATE ZIP CODE
<input type="checkbox"/> Homeless <input type="checkbox"/> Transient	WASHINGTON COUNTY OF RESIDENCE	RSN (IF KNOWN)	
DATE OF BIRTH	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY NUMBER	
DETAINED TO E&T		DATE OF DENTENTION	RELEASED FROM E&T ON
ITA PROVIDER NAME		TITLE	TELEPHONE NUMBER
SIGNATURE OF ITA PROVIDER			DATE

### INFORMATION TO BE SUPPLIED BY BILLER TO DSHS

**Name:** The client's last name, first name, and middle initial (if available)

**Provider One Client ID (CID):** This is the unique Provider One Client ID assigned to a client.

**Address:** The client's address at time of hospitalization.

**Homeless/Transient:** Check one or both if yes, otherwise leave blank.

**Washington County of Residence:** The Washington county listed on the client's medical card. If the consumer does not have a medical coupon, indicate the county in Washington where the consumer resided prior to hospitalization.

**RSN (If known):** The RSN responsible for client services.

**Date of Birth:** The client's date of birth.

**Gender:** The client's gender.

**Social Security Number:** The client's Social Security Number.

**Detained to E&T:** The name of the E&T where involuntary services were provided.

**Date of Detention:** The date when a DMHP signed an initial detention or revocation petition.

**Released From E&T On:** The date when the individual was discharged from the Evaluation and Treatment facility.

**ITA Provider Name:** The name of ITA provider signing this form.

**Title:** The title of the person signing this form.

**Telephone Number:** The telephone number of the ITA provider submitting this form.

**Signature of ITA Provider:** The signature of the person submitting this form.