SUBMIT TO
Utilization Management Department
PHONE 1.844.385.2192 FAX 1.866.593.1955

INTENSIVE OUTPATIENT FORM MENTAL HEALTH/CHEMICAL DEPENDENCY

Please print clearly – incomplete or illegible forms will delay processing. Please mail or fax completed form to the above address.

MEMBER INFORMATION

Member Name_____

DOB _____

SS # _____

Member ID # _____

Last Auth # _____

CURRENT ICD-10 DIAGNOSIS CODE

Primary_____

Secondary_____

Tertiary_____

Additional_____

Additional_____

WHY IS THIS TREATMENT MEDICALLY NECESSARY?

PROVIDER INFORMATION

Check agency or provider to indicate how to authorize.

☐ Agency/Group Name_____

☐ Provider Name _____

Professional Credentials_____

Address/City/State _____

_____

Phone_____Fax_____

NPI (required) _____ Tax ID (required) _____

CURRENT RISK/LETHALITY

Suicidal

☐None ☐Ideation ☐Plan* ☐Means* ☐Intent*

Past attempt date (s): _____

Homicidal

☐None ☐Ideation ☐Plan* ☐Means* ☐Intent*

Past attempt date (s): _____

*Please indicate current safety plans _____

_____

Current assaultive/violent behavior, including frequency _____

_____

Describe any risk for higher level of care, out-of-home placement, change of placement or inability to attend work/school_____

_____

CURRENT PRESENTATION/SYMPTOMS

Describe the CURRENT situation and symptoms. Impact on current functioning (occupational, academic, social, etc.)?

_____

_____ ☐ MILD ☐ MODERATE ☐ SEVERE

_____

_____ ☐ MILD ☐ MODERATE ☐ SEVERE

_____

_____ ☐ MILD ☐ MODERATE ☐ SEVERE

_____

LEVEL OF IMPROVEMENT TO DATE

☐Minor ☐Moderate ☐Major ☐No progress to date ☐Maintenance treatment of chronic condition

_____

_____

_____

_____

MH/SA TREATMENT HISTORY

What has member received in the past?

☐ None ☐ OP MH ☐ OP SA ☐ IP MH ☐ IP SA/DETOX

☐ Other_____

List approx. dates of each service, including hospitalizations_____

_____

CURRENT PSYCHOTROPIC MEDICATIONS

Prescriber: ☐ Psychiatrist ☐ General Practitioner

☐ Other _____

Medication Name Date Started Compliant (Y/N)

_____

Amount and Frequency: _____

_____

Has a psychiatric evaluation been completed? ☐ Yes_____(date) ☐ No / If no, indicate why this has not been completed.

SUBSTANCE USE DISORDER

☐ None ☐ By History ☐ Current/Active Use

DRUG	AMOUNT	FREQUENCY	FIRST USE (DATE)	LAST USE (DATE)

Is member attending AA/NA meetings? ☐ Yes ☐ No If yes, how often? _____

Current step _____ Was a sponsor identified? ☐ Yes ☐ No

RELAPSE HISTORY

Date of last relapse _____

Drug and amount used _____

Resulting consequences _____

_____

TREATMENT DETAILS

What therapeutic approach (e.g. evidence-based practice, therapeutic model, etc.) is being utilized with this member?

_____

_____

Member's current level of motivation? ☐ None ☐ Minimal ☐ Moderate ☐ High

Are the member's family/supports involved in treatment? ☐ Yes ☐ No If no, why? _____

Date of last family therapy session and progress made? _____

_____

What other services are being provided to this member that are not requested in this OTR? Please include frequency _____

_____

_____

Is care being coordinated with member's other service providers? ☐ Yes ☐ No ☐ N/A

Has information been shared with PCP regarding behavioral health provider contact information, presenting problem, date of initial visit, diagnoses and any meds prescribed? ☐ Yes _____(date) ☐ No/ If no, why? _____

TREATMENT GOALS

Describe measurable goals and treatment plan agreed upon by member.

MEASURABLE GOAL	DATE INITIATED	CURRENT PROGRESS (Please note specific progress made.)

TREATMENT CHANGES

How has the treatment plan changed since the last request? _____

_____

_____

_____

_____

DISCHARGE CRITERIA

Objectively describe how it will be known that the member is ready to discontinue treatment. _____

_____

_____

_____

REQUESTED AUTHORIZATION

Please check only one box.

☐ H2014 Intensive Outpatient (IOP)
Date of last Initial Diagnostic Interview: _____

☐ H0015 ASA Intensive Outpatient
Date of last ASA Assessment: _____

☐ S9480 MH IOP
Date of last session: _____

ASAM LOC Recommendation based onASA Assessment:

_____

Date of admission to IOP _____

Total of IOP sessions completed to date _____

Requested start date for auth _____

Requested end date for auth _____

Number of days per week attending _____

Number of hours per day attending _____

S	M	T	W	T	F	S
☐	☐	☐	☐	☐	☐	☐

Additional Information?

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

Clinician Signature Date

Clinician Signature Date