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 II	NFORMATION			PROVIDE	R INFORMATION	ON		
Member N	ame	Check agency or provider to indicate how to authorize.						
DOB Agency/Group Name								
	SS # Provider Name							
	) #	Profession	al Credentials					
	#			Address/C	City/State			
CURRENT	ICD-10 DIAGNOSI	IS CODE		Phone		Fax_		
Primary				Phone				
Secondary_				CURRENT	RISK/LETHALI	ſΥ		
Tertiary				Suicidal				
Additional				□None	□ldeation	□Plan*	□Means*	□Intent
A dditional					mpt date (s):			
Additional_				Homicida				
WHY IS TH	IIS TREATMENT MEI	DICALLY NECES	SSARY?	□None	□Ideation	□Plan*		□Intent
					mpt date (s): dicate current so			
					alcare conom se			
				Current a	ssaultive/violent	behavior, inc	luding frequenc	:у
				Describe o	any risk for highe	r level of care	, out-of-home p	lacement,
				change o	f placement or i	nability to atte	end work/schoo	nl
CURRENT P	PRESENTATION/SYMP	TOMS						
Describe the	CURRENT situation and	symptoms.		Impact on co	urrent functionin	g (occupatior	nal, academic,	social, etc.)?
					MILD		MODERATE	SEVERE
					□ MILD		MODERATE	SEVERE
					□MILD		MODERATE	□SEVERE
LEVEL OF I	MPROVEMENT TO DA		□No progress t	o data	□Maintonar	oco troatmont	of chronic con	dition
□///III/IOI	□Modelale	□Major	□140 blogless	o dale	⊔Maimenai	ice ireaimeni	Of Chiloffic Coff	amori

MH/SA TREATMENT HISTORY					CURRENT PSYCHOTROPIC MEDICATIONS					
What has	member rece	ived in the po	ıst?		Prescriber:	□Psychiatrist	□Genera	l Practitioner		
□None	□ОР МН	□ OP SA	□IP MH	□IP SA/DETOX	☐ Other					
☐ Other_					Medication	Name	Date Started	Compliant (Y/N)		
List appro	x. dates of ea	ch service, inc	cluding hospite	alizations						
					Amount and F	requency:				
Has a psych	niatric evaluat	ion been con	npleted?	Yes(date)	□No / If no, inc	dicate why this h	as not been comp	leted.		
,.						,				
SUBSTAN	ICE USE DISC									
☐ None			rent/Active Us	e 						
DRIIG		AMOUN	IT		FIRST	USE (DATE)	LAST USE	(DATE)		
•										
Is member of	attending AA/	'NA meetings'	? □Yes	□ No If yes, how o	often?					
Current step	o			Was a spons	sor identified?	□ Yes □No				
RELAPSE	HISTORY									
Date of last	relapse									
Drug and a	mount used _									
Resulting co	onsequences _									
TREATME	NT DETAILS									
What thera	peutic approc	ach (e.g. evid	ence-based p	ractice, therapeutic n	nodel, etc.) is beir	ng utilized with th	is member?			
	current level of mber's family/		□ Non		☐ Moderate	□Hig	n			
	family therap				ii iio, wiiy =					
Date of last	тапшу ттогар	y 30331011 arra	progress maa	O F						
What other	services are b	eing provided	d to this memb	per that are not reques	ited in this OTR? P	lease include fre	quency			
				·						
ls care bein	g coordinated	d with membe	er's other servi	ce providers? 🗆 Yes		N/A				
Has informo	ation been sha	red with PCP	regarding bel	navioral health provide	er contact informa	ation, presenting	problem, date of	initial visit, diagnoses		
and any ma	eds prescribed	4S LIVES	14	ate) MNO/If no why	./S					

Discharge Criteria	TREATMENT GOALS									
DATE INITIATED   CURRENT PROCRESS (Please note specific progress mode.)										
DISCHARGE CRITERIA	MEASURABLE GOAL	DATE INITIATED			CURRENT PROGRESS (Please note specific progress made.)					
DISCHARGE CRITERIA										
DISCHARGE CRITERIA										
INCOME AND AUTHORIZATION  REQUESTED AUTHORIZATION  Please check only one box.    H2014 Intensive Outpatient (IOP) Dote of tail hilling blaceatic hierarchy   H01015 ASA Intensive Outpatient (IOP) Dote of tail hilling blaceatic hierarchy   H0105 ASA Intensive Outpatient (IOP) Dote of tail hilling blaceatic hierarchy   H0105 ASA Intensive Outpatient (IOP) Dote of tail hilling blaceatic hierarchy   H0105 ASA Intensive Outpatient (IOP) Dote of tail hilling blaceatic hierarchy   H0105 ASA Intensive Outpatient (IOP) Dote of tail hilling blaceatic hierarchy   H0105 ASA Intensive Outpatient (IOP) Dote of tail hilling blaceatic hierarchy   H0105 ASA Intensive Outpatient (IOP) Dote of tail hilling blaceatic hierarchy   H0105 ASA Intensive Outpatient (IOP) Dote of tail hilling blaceatic hierarchy   H0105 ASA Intensive Outpatient (IOP) Dote of tail hilling blaceatic hierarchy   H0105 ASA Intensive Outpatient (IOP) Dote of tail hilling blaceatic hierarchy   H0105 ASA Intensive Outpatient (IOP)   Number of hours per day attending     Number of hours per day										
DISCHARGE CRITERIA										
How has the treatment plan changed since the last request?    Cobjectively describe how if will be known that the member is ready to discontinue treatment.					··· <u>;</u>					
REQUESTED AUTHORIZATION  Please check only one box.    Date of admission to IOP	TREATMENT CHANGES			DISCH	ARGE CRITER	IA				
REQUESTED AUTHORIZATION  Please check only one box.    H2014 Intensive Outpatient (IOP) Doe to last instal bagross crimerwow   H2014 Intensive Outpatient   H2015 AsA Intensive Outpatient   H2015 AsA Intensive Outpatient   Great data fast Adaestronit.   Great data fast Adaestronit.   Great data fast Adaestronit.   Great data fast out data for outh   Requested and date for outh   Number of days per week attending     Number of hours per day attending     Number of hours per day attending     Additional Information?    Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).	How has the treatment plan change	ed since the last re	quest?	Object	ively describe h	ow it will be kno	wn that the me	mber is ready		
REQUESTED AUTHORIZATION  Please check only one box.    H2014 Intensive Outpatient (IOP) Doe to last instal bagross crimerwow   H2014 Intensive Outpatient   H2015 AsA Intensive Outpatient   H2015 AsA Intensive Outpatient   Great data fast Adaestronit.   Great data fast Adaestronit.   Great data fast Adaestronit.   Great data fast out data for outh   Requested and date for outh   Number of days per week attending     Number of hours per day attending     Number of hours per day attending     Additional Information?    Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).				to disc	ontinue treatme	ent				
Please check only one box.    H2014 Intensive Outpatient (ICP) Date of last Milliad Diagnostic Intensive Outpatient     H3015 ASA Intensive Outpatient     H3016 Intensive Outpatient     H3016 Intensive Outpatient     H3016 Intensive Outpatient     H3016 Intensive Outpatient     Sy480 MH ICP     Date of last As Assessment:     S M T W T F S										
Please check only one box.    H2014 Intensive Outpatient (ICP) Date of last Milliad Diagnostic Intensive Outpatient     H3015 ASA Intensive Outpatient     H3016 Intensive Outpatient     H3016 Intensive Outpatient     H3016 Intensive Outpatient     H3016 Intensive Outpatient     Sy480 MH ICP     Date of last As Assessment:     S M T W T F S										
Please check only one box.    H2014 Intensive Outpatient (ICP)   Date of last Mailad Diagnostic Intensive Outpatient     H3015 ASA Intensive Outpatient     H3015 ASA Intensive Outpatient     Sy480 MH IOP     Date of last Massuramit:     Sy MM   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.)).										
Please check only one box.    H2014 Intensive Outpatient (ICP)   Date of last Mailad Diagnostic Intensive Outpatient     H3015 ASA Intensive Outpatient     H3015 ASA Intensive Outpatient     Sy480 MH IOP     Date of last Massuramit:     Sy MM   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.)).										
H2014 Intensive Outpatient (IOP)   Date of last Asia Assessment:     H0015 ASA Intensive Outpatient	REQUESTED AUTHORIZATION									
Date of kast Infilial Diagnostic Interview:    H0015 ASA Intensive Outpatient   Requested start date for auth   Requested end date for auth   Number of days per week attending   Number of hours per day attendin	Please check only one box.	Date of admiss	ion to IOP							
Houts AsA Intensive Outpatient   Requested start date for outm   Requested end date for auth   Number of days per week attending   Number of hours per day attending   Numbe		Total of IOP ses	sions complete	d to date						
Requested end date for auth   Number of days per week attending   Number of hours per day attending		Requested star	t date for auth							
ASAM LOC Recommendation based on ASA Assessment:  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.).	Date of last ASA Assessment:	Requested end	date for auth .							
ASAM LOC Recommendation based on ASA Assessment:  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.).		Number of day	s per week atte	ending						
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.).		Number of hou	rs per day atter	nding						
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.).										
Additional Information?  Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).	017/07/7/03033110111.									
Additional Information?  Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).		S	М	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.).		П	П	П	П	П	П	П		
Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).			<u> </u>				<u> </u>			
	Additional Information?									
:linician Sianature Date Clinician Sianature Date	Please feel free to attach addition	al documentation	n to support yo	ur request (e.g	. updated trea	tment plan, pro	gress notes, e	tc.).		
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Clinician Signature Date Clinician Signature Date										
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