SUBMIT TO

Utilization Management Department

Phone: 1.877.647.4848 Fax: 1.866.694.3649



INTENSIVE OUTPATIENT/DAY TREATMENT 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	PROVIDER INFORMATION
Member Name	Check agency or provider to indicate how to authorize.
wender vane	☐ Agency/Group Name
DOB	☐ Provider Name
Social Security #	Professional Credentials
Member ID #	Address/City/State
Last Auth #	Phone Fax
CURRENT ICD DIAGNOSIS	NPI (required) Tax ID (required)
Primary (Required)	CURRENT RISK/LETHALITY
Secondary	Suicidal □ None □ Ideation □ Plan* □ Means* □ Intent*
,	Past attempt date (s):
Tertiary	Homicidal
Additional	□ None □ Ideation □ Plan* □ Means* □ Intent*
Additional	Past attempt date (s):
WHY DID THE MEMBER ORIGINALLY PRESENT FOR TREATMENT?	*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
MH/SUD TREATMENT HISTORY	CURRENT PSYCHOTROPIC MEDICATIONS
What has member received in the past?	Prescriber: ☐ Psychiatrist ☐ General Practitioner
None □ OP MH □ OP SUD □ IP MH □ IP SUD/DETOX	□ Other
Other List approx. dates of each service, including hospitalizations	Medication Name Date Started Compliant (Y/N)
	Amount and Frequency:

					Member	Nam
Has a psychiatric evaluation bee	n completed? Yes □	(date) □ I	No / If no, indicate why this has r	not been completed.		
SUBSTANCE USE DISO	RDER					
☐ None ☐ By History	☐ Current/Active Use					
•	AMOUNT	FREQUENCY	FIRST USE	LAST USE		
Is mamber attending AA/NA most	tings? Vos 🗆 No 🗆 If	i	:	<u> </u>		
Is member attending AA/NA mee						
Current step		Was a sponso	r 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 ther	aneutic model, etc.) is be	ng utilized with this member?			
Trial increposite approach (c.g.	ovidonico bacca practico, trici	apoullo model, etc., le se	ng danzod war and member.			
Member's current level of motivation	tion? ☐ None ☐ Minimal	☐ Moderate ☐ F	ligh			
Are the member's family/supports	s involved in treatment? Y	es □ No If no, why	?			
Date of last family therapy session	n and progress made?					
What other services are being pro	ovided to this member that are	e not requested in this OT	R? Please include frequency			
Is care being coordinated with me	ember's other service provider	rs? □ Yes □ N	o 🗆 N/A			
Has information been shared with	n PCP regarding behavioral he	ealth provider contact info	rmation, presenting problem, da	te of initial visit, diagno	ses and any	meds
prescribed? Yes	(date)					
TREATMENT GOALS						
Describe measurable goals and t						
MEASURABLE GOAL	DATE INIT	IATED		SS (Please note specific pro		

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TREATMENT CHANGES		DISCHARGE CRITERIA		
How has the treatment plan changed since the last request?		Objectively describe how it will be known that the member is ready to discontinue treatment.		
REQUESTED AUTHORIZATION				
Please check only one box.	Date of admission to IOP/Day Trea	atment		
☐ REV 905 (Mental Health IOP) ☐ REV 906 (CD IOP)	Total of IOP/Day Treatment sessions completed to date			
☐ REV 907 (Day Treatment)	Requested start date for auth			
☐ HCPCS H0015 (Alcohol and/or drug services intensive outpatient treatment)	Number of days per week attending			
☐ HCPCS S9480 (Intensive outpatient psychiatric services per diem)	Number of hours per day attending			
☐ HCPCS H0038	Expected discharge date			
Please attach additional documentati	on to support your request (e.g	updated treatment plans,progress notes etc).		
Clinician Name		Clinician Signature Date (not to exceed 30 days prior to submission)		
		SUBMIT TO Utilization Management Department 12515-8 Research Blvd., Suite 400 Austin, Texas 78759 PHONE 1.877.647.4848 FAX 1.866.694.3649		