illinicare health

SUBMIT TO
Utilization Management Department
PHONE 866-329-4701 | FAX 844-528-3453

Intensive Outpatient Services Request – Mental Health and Chemical Dependency

Please print clearly – incomplete or illegible forms will delay processing. Please fax completed form to the above address. ALL SECTIONS MUST BE COMPLETED.

Date_____

MEMBER INFORMATION

Member Name_____

DOB _____

Member ID # _____

Last Auth # _____

PROVISIONAL ICD DIAGNOSIS

Primary _____

Secondary_____

Tertiary _____

Additional _____

Additional_____

WHY DID THE MEMBER ORIGINALLY PRESENT FOR TREATMENT?

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) _____

PAST IDEATION/ATTEMPT DATE(S):

Suicidal

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

Past ideation/attempt date(s): _____

Homicidal

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

Past ideation/attempt date(s):_____

_____

Please provide additional information for any boxes checked above:_____

_____

*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. Please provide specific information demonstrating the level of impairment and overall impact, including triggers.

☐MILD ☐ MODERATE ☐ SEVERE _____

☐MILD ☐ MODERATE ☐ SEVERE _____

☐MILD ☐ MODERATE ☐ SEVERE _____

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)

_____Member Name

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? _____

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.)

_____Member Name

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.

☐ 913 (Hospital IOP for MH & SA)

☐ S9480 (CMHC MH IOP)

☐ H0005 (DASA)

Date of admission to IOP: _____

Total of IOP/Day sessions completed to date _____

Requested start date for auth _____

Number of days per week attending _____

Number of hours per day attending _____

Requested end date for auth (Not to exceed 4 weeks) _____

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

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