



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 # _____

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) _____

PROVISIONAL ICD DIAGNOSIS

Primary _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

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): _____

WHY DID THE MEMBER ORIGINALLY PRESENT FOR TREATMENT?

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 _____

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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)

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.)

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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