SUBMIT TO
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
PHONE 1.844.385.2192 | FAX 1.866.593.1955

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

Member Name____________________

Health Plan ____________________

DOB____________________

SS #____________________

Member ID # ____________________

Last Auth #____________________

CURRENT ICD DIAGNOSIS

Primary (Required) ____________________

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) ____________

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

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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: ____________

ASAM LOC Recommendation based on ASA Assessment: ____________

____

Date of admission to IOP/Day Treatment ____________________

Total of IOP/Day Treatment sessions completed to date ____________________

Requested start date for auth ____________________

Number of days per week 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.).

____

Clinician Signature Date

____

Clinician Signature Date