

SUBMIT TO:
Utilization Management Department
 5900 E. Ben White Blvd.
 Austin, TX 78741
 PHONE 1-844-842-2537
 FAX 1-866-900-6918



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?

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/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

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 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.)

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.

- REV 905 (Behavioral Health IOP)
- REV 906 (SUD IOP)
- REV 907
(Behavioral Health Day Treatment)

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 _____

Expected discharge date _____

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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