SUBMIT TO
Utilization Management Department
PHONE 1-866-595-8133 | FAX 1-888-725-0101

louisiana healthcare connections™

Intensive Outpatient/Partial Hospitalization form Mental Health/Chemical Dependency

Please print clearly – incomplete or illegible forms will delay processing.

MEMBER INFORMATION

Member Name______________________________

DOB______________________________

Member ID # ______________________________

Last Auth # ______________________________

CURRENT 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) ______________

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

______________________________ ☐ 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)

____

____

Amount and Frequency: ______________________________

____

______________________________________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? ______________________________

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 (Mental Health IOP)
- ☐ REV 906 (CD IOP)
- ☐ REV 907 (Partial Hospitalization)
- ☐ REV 907 (IOP/Partial)
- ☐ REV 912 (IOP/Partial)
- ☐ REV 913 (IOP/Partial)
- ☐ H0015 (CD IOP)

Date of admission to IOP/ Partial Hospitalization______________________

Total of IOP/ Partial Hospitalization 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 Name	Clinician Signature	Date

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