

## Intensive Outpatient/Partial Hospitalization form Mental Health/Chemical Dependency

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

### MEMBER INFORMATION

Member Name \_\_\_\_\_

DOB \_\_\_\_\_

SS # \_\_\_\_\_

Member ID # \_\_\_\_\_

Last Auth # \_\_\_\_\_

### CURRENT ICD DIAGNOSIS

Primary \_\_\_\_\_

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.) ?

_____	<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE
_____	<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE
_____	<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> 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?

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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 \_\_\_\_\_

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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.

- 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

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