Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
PHONE: 1.866.912.6285
FAX: 1.866.694.3649

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_______________________

Social Security # _______________________

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.)

Have any questions?
Call us at 1.866.912.6285

_______________________________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.

☐ S9480

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 Name

____
Clinician Signature Date

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