FROM

**SUBMIT TO:**
**Utilization Management Department**
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339
PHONE 1.877.687.1180
Inpatient Fax 844.561.7857
Outpatient Fax 844.256.1291

# 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

▯ 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 (Behavioral Health IOP)

▯ REV 906 (SUD IOP)

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


**SUBMIT TO:**

**Utilization Management Department**

1100 Circle 75 Parkway, Suite 1100

Atlanta, GA 30339

PHONE 1.877.687.1180

Inpatient Fax 844.561.7857

Outpatient Fax 844.256.1291