

**SUBMIT TO:**

**Utilization Management Department**  
12515-8 Research Blvd., Suite 400  
Austin, Texas 78759  
PHONE 1.877.617.0390  
FAX 1.866.279.1358



**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?**

Empty box for text input.

**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

Empty lines for text input.

**CURRENT PSYCHOTROPIC MEDICATIONS**

**Prescriber:**  Psychiatrist  General Practitioner

Other \_\_\_\_\_

Medication Name Date Started Compliant (Y/N)

Empty lines for text input.

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.)

**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) AR

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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