



SUBMIT TO  
 Utilization Management Department  
 504 Lavaca, Suite 850, Austin, Texas 78701  
 FAX 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 Identification**

MEMBER NAME \_\_\_\_\_  
 HEALTH PLAN \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_  
 SS # \_\_\_\_\_  
 MEMBER ID # \_\_\_\_\_  
 LAST AUTH # \_\_\_\_\_

**DSM Axes**

Please complete all axes.

AXIS I \_\_\_\_\_  
 -----  
 AXIS II \_\_\_\_\_  
 -----  
 AXIS III \_\_\_\_\_  
 -----  
 AXIS IV \_\_\_\_\_  
 -----  
 AXIS V Current \_\_\_\_\_ Highest in past year \_\_\_\_\_

**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.)?

\_\_\_\_\_

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:  
 \_\_\_\_\_

**Provider Identification**

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)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has a psychiatric evaluation been completed?  YES \_\_\_\_\_ (date)  NO If no, indicate why this has not been completed:

**Substance Abuse**

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?

[Empty text box for Treatment Changes]

**Discharge Criteria**

Objectively describe how it will be known that the member is ready to discontinue treatment.

[Empty text box for Discharge Criteria]

**Requested Authorization**

(Please check only one box.)

- REV 905 (MENTAL HEALTH IOP)
- REV 906 (CD IOP)
- REV 907 (DAY TREATMENT)
- H2012       H0015

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?

[Empty text box for Additional information]

PROVIDER NAME \_\_\_\_\_

PROVIDER SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

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