

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 STAR STAR+PLUS CHIP RSA _____
 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?

Member's treatment court-ordered? YES NO

If yes, include copy of court order with this OTR.

Current Presentation/Symptoms

Describe the CURRENT situation and symptoms.

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:

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) |
|-----------------|--------------|------------------|
| | | |
| | | |
| | | |

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? _____

For STAR HEALTH members, please report level of care (e.g. basic, moderate, specialized, etc): _____

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 (BH DAY TREATMENT)
1 hour units

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.).

SUBMIT TO
 Utilization Management Department
 504 Lavaca, Suite 850, Austin, Texas 78701
 PHONE 800.466.4089 FAX 866.694.3649