



Utilization Management Department
 PHONE: 800-589-3186
 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 INFORMATION

Member Name _____
 DOB _____
 Social Security # _____
 Member ID # _____
 Last Auth # _____

CURRENT ICD DIAGNOSIS

Primary _____
 Secondary _____
 Tertiary _____
 Additional _____
 Additional _____

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 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 PSYCHOTROPIC MEDICATIONS

Prescriber: Psychiatrist General Practitioner

Other _____

Medication Name Date Started Compliant (Y/N)

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.)

