Utilization Management Department
PHONE: 1.888.282.7767
FAX: 1.866.694.3649

nh healthy families.

Intensive Outpatient/Day Treatment Form Mental Health/Chemical Dependency

To be completed by non-participating providers only. Serviced specific to Health Protection Program members only.
Please print clearly-incomplete of illegible forms will delay processing. Please mail or fax completed form to the above address.

Date:_____

MEMBER INFORMATION

Member Name_____

DOB _____

SS # _____

Member ID # _____

Last Auth # _____

CURRENT ICD-10 DIAGNOSIS CODE

Primary_____

Secondary_____

Tertiary_____

Additional_____

Additional_____

WHY IS THIS TREATMENT MEDICALLY NECESSARY?

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 (PLEASE ENSURE THAT GOALS ARE S.M.A.R.T : SPECIFIC, MEASURABLE, ACHIEVABLE, REALISTIC, AND TIME BOUND)

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 (Mental Health IOP)
- ☐ REV 906 (CD IOP)
- ☐ HCPCS H0015 (Alcohol and/or drug services intensive outpatient treatment)
- ☐ HCPCS S9480 (Intensive outpatient psychiatric services per diem)
- ☐ Other:_____

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 attach additional documentation to support your request (e.g. Assessment, progress notes, updated treatment plan).

Clinician Signature

Date (Not to exceed 30 days of submission)

Clinician Signature

Date (Not to exceed 30 days of submission)

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