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

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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 906 (CD IOP)
- ☐ H0015 SUD IOP, per diem
- ☐ H2036 PHP, integrated MH/SUD
- ☐ H0049 Alcohol and/or drug screening
- ☐ H0038 Peer Recovery Support
- ☐ H0038 (HQ) Peer Recovery Support Group
- ☐ T1012 Non Peer Recovery Support
- ☐ T1012(HQ) Non Peer Recovery Support Group
- ☐ H0006 (CM/continuous monitoring)

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 ________

End date of requested authorization ________

Amount of total units requested for authorization period ________

S	M	T	W	T	F	S
☐	☐	☐	☐	☐	☐	☐

Additional Information?

PPlease 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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