NH Healthy Families
Utilization Management Department
2 Executive Park Drive, Bedford, NH 03110
PHONE: 1.888.282.7767
FAX: 1.866.694.3649

nh healthy families.

Mental Health Intensive Outpatient Request Form

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)
- ☐ 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)

NH Healthy Families
Utilization Management Department
2 Executive Park Drive, Bedford, NH 03110
PHONE: 1.888.282.7767
FAX: 1.866.694.3649