YouthCare HealthChoice Illinois

SUBMIT TO
Utilization Management Department
PHONE 844-289-2264 | FAX 844-989-0154

Intensive Outpatient Services Request – Mental Health and Chemical Dependency

Please print clearly – incomplete or illegible forms will delay processing. ALL SECTIONS MUST BE COMPLETED.

Date____

MEMBER INFORMATION

Member Name______________________________

DOB ______________________________

Member ID # ______________________________

Last Auth # ______________________________

PROVISIONAL ICD DIAGNOSIS

Primary ______________________________

Secondary______________________________

Tertiary ______________________________

Additional ______________________________

Additional______________________________

WHY DID THE MEMBER ORIGINALLY PRESENT FOR TREATMENT?

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) ______________________________

PAST IDEATION/ATTEMPT DATE(S):

Suicidal

☐None ☐Ideation ☐Plan* ☐Means* ☐Intent*

Past ideation/attempt date(s): ______________________________

Homicidal

☐None ☐Ideation ☐Plan* ☐Means* ☐Intent*

Past ideation/attempt date(s):______________________________

____

Please provide additional information for any boxes checked above:______________________________

____

*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. Please provide specific information demonstrating the level of impairment and overall impact, including triggers.

☐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)

______________________________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? ____________________

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.)

_______________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.

- ☐ 913 (Hospital IOP for MH & SA)
- ☐ S9480 (CMHC MH IOP)
- ☐ H0005 (DASA)

Date of admission to IOP: _______________

Total of IOP/Day sessions completed to date _______________

Requested start date for auth _______________

Number of days per week attending _______________

Number of hours per day attending _______________

Requested end date for auth (Not to exceed 4 weeks) _______________

Additional Information?

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

____

Clinician Signature Date

____

Clinician Signature Date

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