ambetter. FROM sunflower health plan

**SUBMIT TO:**
**Utilization Management Department**
PHONE 1.844.518.9505 FAX 1.844.811.5380

# 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 _____

Health Plan _____

DOB _____

SS # _____

Member ID # _____

Last Auth # _____

## CURRENT ICD DIAGNOSIS

Primary (Required) _____

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) _____

## 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

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 (Behavioral Health IOP)
❏ REV 906 (SUD IOP) AR

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

Clinician Signature Date

Clinician Signature Date

**SUBMIT TO:**
**Utilization Management Department**
PHONE 1.844.265.1278 FAX 1.844.811.5380

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