Intensive Outpatient/Partial Hospitalization Request Form

Please note that most lines of business do not require an authorization for IOP/PHP until the member has completed 30 sessions/dates of service. If you have a question as to the member's benefit, please call customer service at 1.877.221.9295

MEMBER INFORMATION	
Member Name: _____	Date of Request: _____
Member ID: _____	Date of Birth: _____
Provider/Facility Name: _____	
Program Name: _____	Contact Phone Number: _____
Address: _____	
_____	
Physician Overseer: _____	
Diagnosis: _____	ICD-10: _____
Diagnosis: _____	ICD-10: _____
Diagnosis: _____	ICD-10: _____
Diagnosis: _____	ICD-10: _____
Diagnosis: _____	ICD-10: _____
Date of Last Inpatient Admission: _____	Expected Adherence to the Program: ____ %
Potential For Non-Adherence: ☐ Y ☐ N	Present Adherence to the Program: ____ %
Available Support System: ☐ Y ☐ N	Adequate Support System: ☐ Y ☐ N
Transportation Available: ☐ Y ☐ N	

SYMPTOMS:	Present	Resolved	N/A
Self-destructive behavior	☐	☐	☐
Recklessness	☐	☐	☐
Impulsive behavior	☐	☐	☐
Compulsive behavior	☐	☐	☐
SI/HI w/o plan or intent	☐	☐	☐
Medication resistant	☐	☐	☐
Depression	☐	☐	☐
Anxiety	☐	☐	☐
Thought disturbances	☐	☐	☐
Self-injurious behavior	☐	☐	☐
Severe cravings	☐	☐	☐
Preoccupied with substance use disorder	☐	☐	☐
Preoccupied with substance use disorder experience	☐	☐	☐
Guilt/remorse	☐	☐	☐
Drug seeking behavior	☐	☐	☐
Drug induced psychosis	☐	☐	☐
Altered mood	☐	☐	☐
Withdrawal symptoms	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

SERVICES PROVIDED:	Yes	No	N/A
Individual therapy	☐	☐	☐
Group therapy	☐	☐	☐
Family therapy	☐	☐	☐
Medication evaluation	☐	☐	☐
Crisis planning	☐	☐	☐
Recovery based activities	☐	☐	☐
Identification of goals/triggers	☐	☐	☐

ADDITIONAL INFORMATION (PLEASE LIMIT TO 600 CHARACTERS):