Intensive Outpatient Program
Continued Care Authorization Request

For Medica members, please fax completed form to 1/855-454-8155
Call 1-800-848-8327 for Medica eligibility and benefit questions.

DO NOT USE THIS FORM IF THIS IS
THE INITIAL IOP TREATMENT REQUEST TO MBH FOR THIS MEMBER

DATES OF SERVICE:

Original admit date: _____ Proposed discharge date: _____

First date of this request: _____ End date of this request: _____

# of Days per week: _____ Contracted IOP Code _____

IOP Treatment Program Name: _____ Tax ID: _____

Program Address: _____

Clinician: _____

Phone & Fax: _____

Member Name: _____ DOB: _____

Medica #_____

Current symptoms, behaviors and progress made toward symptom reduction (stated in terms of frequency, severity, impact):

_____

_____

_____

Proposed modification in treatment plan to address remaining symptoms or regression:

_____

_____

_____

Updated DSM5 Diagnosis:_____

_____

Current medication: Prescribing Psychiatrist: _____

Name	Dosage	Frequency

When was the last psychiatric visit? _____

Describe family/social support (if none, describe planned interventions): _____

Transitional or discharge plans for mental health needs:

Member's/Family's crisis assistance plan: _____

Based on the OptumHealth Continued Service Criteria, or Optum Coverage Determination Guidelines, what is the rationale for continued authorization for this member? _____

A copy of this Treatment Plan or brief Treatment Summary must be sent to the patient's primary physician upon appropriate patient consent.

- ☐ Treatment Plan or Summary sent to member's primary physician
- ☐ Member/parent/guardian refused to consent for release to primary physician
- ☐ Member states they have no primary physician

In addition to this form, please include any new information (psychological reports, school reports, psychiatric notes or reports) that will assist in evaluating the Member's needs