ambetter. FROM sunflower health plan
Insured by Celtic Insurance Company

SUBMIT TO: Utilization Management Dept.
Phone 1-844-518-9505 Fax: 1-844-824-7705

❍ **Standard Request** - Determination within 14 calender days of receiving all necessary information

❍ **Urgent Request** - Determiniation within 72 hours. **URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.**

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.).

Standard Request - Determination within 14 calender days of receiving all necessary information

_____
Clinician Signature Date

Urgent Request - I certify this request is urgent to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function, within 72 hours.

_____
Clinician Signature Date

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