Intensive Outpatient Program (IOP)

IOP REQUEST FORM

This is a request to review whether treatment meets the medical necessity definition under the member's health benefit plan. It does not confirm eligibility of benefits. For Initial Services, the Provider must call BCBSIL at **800-851-7498** to check benefits.

Instructions: For initial services, complete this form, print and fax to BCBSIL at **877-361-7656**, or access the Availity® Authorizations tool and submit online.

Date___________

Check One:	☐ Initial Request ☐ Concurrent ☐ Discharge	Check One:	☐ CD ☐ MH ☐ ED

Patient Name_______________________ Patient Date of Birth_______________________

Subscriber Name_______________________ Subscriber ID_______________ Group_______________

Facility/Provider Name _______________________ NPI _______________________

Address _______________________ City _______________State_______ Zip________

MD/Program Dir. Name _______________________ MD NPI _______________________

Address _______________________ City _______________State_______ Zip________

UR/Contact Name _______________________ Phone _______________ Ext. _________ Fax _____________

Days Per Week (#) _________ Hrs Per Day (#) _________

Are the total hours per week between 9-20 hrs? ☐ Yes ☐ No

Sessions Requested (#) ________

Start Date of Additional Sessions Requested _______________

Date Mbr Started IOP ____________ Total Days Used (#) _______

IOP End Date _________________

Treatment days of the week, please check.

☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S ☐ S

☐ In-network provider ☐ Out-of-network provider

Current DX — Please list ICD-10 code, Diagnosis Name, Specifier and all Medical Diagnoses

ICD-10 Code ________________ DX Name ____________________________ Specifier ____________________________

ICD-10 Code ________________ DX Name ____________________________ Specifier ____________________________

ICD-10 Code ________________ DX Name ____________________________ Specifier ____________________________

Medications (Dosages)

1. Previous MH/CD/ED Treatment (Reason for same level of care transfer, if applicable)

2. Current Treatment Goals

3. Aftercare Plan (Provider names, telephone #, appointment date and time)

Current Clinical Presentation

1. Current Mental Status (Substance DO – date of first use, pattern of use, last date of use, cravings and severity; Eating DO – include HT, WT, BMI)

2. Current Risk Factors (SI, HI, Psychosis, Medical, ADLs or current functional impairments that can't be addressed in lower level of care)

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3. Progress on treatment goals and barriers to progress

Please complete form in its entirety. Incomplete forms cannot be processed and will require resubmission.

Do not send medical records.

Additional clinical information can be attached if there is inadequate space on the form.

My signature confirms that I, or the facility I represent, will provide the requested services.

Signature ____ Date ____________

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