Submit to:
Aetna Better Health of Illinois UM
Phone 1-866-329-4701/Fax 1-844-528-3453

Aetna Better Health® of Illinois

Intensive Outpatient Services Request – Mental Health and Chemical Dependency

Please print clearly – incomplete or illegible forms will delay processing. Please fax completed form to the above address. ALL SECTIONS MUST BE COMPLETED.

Date_____

MEMBER INFORMATION

Member Name_____

DOB _____

Member ID # _____

Last Auth # _____

PROVISIONAL ICD DIAGNOSIS

Primary_____

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) _____

PAST IDEATION/ATTEMPT DATE(S):

Suicidal

☐ None ☐ Ideation ☐ Plan* ☐ Means* ☐ Intent*

Past ideation/attempt date(s): _____

Homicidal

☐ None ☐ Ideation ☐ Plan* ☐ Means* ☐ Intent*

Past ideation/attempt date(s):_____

_____

Please provide additional information for any boxes checked above:_____

_____

*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. Please provide specific information demonstrating the level of impairment and overall impact, including triggers.

☐ 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)
		☐ ☐
		☐ ☐
		☐ ☐
		☐ ☐

Has a psychiatric evaluation been completed? ☐ Yes_____(date) ☐ No / If no, indicate why this has not been completed.

SUBSTANCE USE DISORDER

☐ None ☐ Rx 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_____

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.)

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.

- ☐ 913 (Hospital IOP for MH & SA)
- ☐ S9480 (CMHC MH IOP)
- ☐ H0005 (DASA)

Date of admission to IOP:

Total of IOP/Day sessions completed to date :

Requested start date for auth:

Number of days per week attending:

Number of hours per day attending:

Requested end date for auth (Not to exceed 4 weeks):

Additional Information?

Confirm by checking here that the following are included with this IOP request.

- ☐ Initial Assessment
- ☐ Continued Stay: Updated treatment plan and last five progress notes
- ☐ Step down from higher level of care: step down assessment/evalutation/note

Clinician Signature_____ Date_____

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Reset