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 BCBSTX at **800-528-7264** to check benefits.

Instructions: For Initial Services, submit completed form through iExchange® or print and fax completed form to BCBSTX at **877-361-7646.**

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)

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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)

BlueCross BlueShield of Texas

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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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