BlueCross BlueShield of Montana

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 BCBSMT at **855-313-8909** to check benefits.

Instructions: For Initial Services, submit completed form through iExchange® or print and fax completed form to BCBSMT at **855-649-9681.**

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

☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S ☐ S

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)

BlueCross BlueShield of Montana

IOP REQUEST FORM

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 __________________

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

354317.0319