



**INTENSIVE OUTPATIENT TREATMENT FORM
CHEMICAL DEPENDENCY**

Please print clearly--incomplete or illegible forms will delay processing.

Member's Name: _____	Insurance Plan: _____
Members SSN: _____ - _____ - _____	Members ID#: _____
DOB: _____	TODAYS' DATE: _____
DATE OF ADMISSION: _____	NUMBER OF SESSIONS COMPLETED: _____
EXPECTED DISCHARGE DATE: _____	NUMBER OF SESSIONS REQUESTED: _____

IOP FACILITY: _____	THERAPIST: _____
TAX ID#: _____	
Address: _____	City, State, Zip: _____
Phone: (____) _____ - _____	Fax: (____) _____ - _____

Diagnosis:

DSM-IV CODES	
Axis I (primary):	
Axis I (secondary):	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	Current: Past Year:

Medication (Psychotropic)	Amount	Frequency
1.		
2.		
3.		
4.		
5.		
6.		

SUBSTANCE ABUSE HISTORY:
DATE OF LAST USE:

SUBSTANCE ABUSE TREATMENT HISTORY:

Please return completed form to: CBH Utilization Management
504 Lavaca, Suite 850 ♦ Austin, Texas 78701

800-947-0633 ♦ 512.406.7215 (fax)

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