



INTENSIVE OUTPATIENT TREATMENT FORM
MENTAL HEALTH

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.		

PREVIOUS MENTAL HEALTH HISTORY:

CURRENT SYMPTOMS:

1. Indicate the *goals* for treatment, *progress toward each goal*, and the *clinical interventions* for each goal:

Goals	Progress Toward Goal	Clinical Interventions
A.		
B.		
C.		

Date of Family Therapy Session: _____

4. Indicate the *date* of the family therapy session, and progress made (if appropriate):

5. Progress toward discharge? _____

6. What modifications to previous treatment plan have been made to facilitate progress?

PROVIDER SIGNATURE

DATE

() _____
PHONE NUMBER

PROVIDER PRINTED NAME

This authorization is only for the services and number of visits indicated. This authorization is not a guarantee that claims will be paid. Reimbursement will be in accordance with the plan provisions, including all limitations and exclusions, and providing that the patient is covered under the plan when the charges are incurred.

Please return completed form to: CBH Utilization Management

504 Lavaca, Suite 850 ♦ Austin, Texas 78701

800-947-0633 ♦ 512.406.7215 (fax)

Revised 1-13-06