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, providers must call Blue Cross and Blue Shield of Montana (BCBSMT) at **855-313-8909** to check benefits.

Instructions: For initial services, complete this form, print and fax to BCBSMT at **855-649-9681**, or access the Availity® Essentials Authorizations tool and submit online.

Date _____

Check One: ☐ Initial Request ☐ Concurrent ☐ Discharge

Check One: ☐ Chemical Dependency ☐ Mental Health ☐ Eating Disorder

Patient Name _____ Patient Date of Birth _____

Subscriber Name _____ Subscriber ID _____ Group _____

Facility/Provider Name _____ NPI _____

Address _____ City _____ State _____ Zip _____

MD/Program Director Name _____ MD NPI _____

Address _____ City _____ State _____ Zip _____

Utilization Reviewer/Contact Name _____ Phone _____ Ext. _____ Fax _____

Days per week (#) _____ Hours per day (#) _____ Are the total hours per week between 9-20 hrs? ☐ Yes ☐ No

Sessions requested (#) _____ Start date of additional sessions requested _____

Date member started IOP _____ Total days used (#) _____ IOP end date _____

Please check treatment days of the week: ☐ In-network provider ☐ Out-of-network provider

☐ M ☐ T ☐ W ☐ TH ☐ F ☐ SAT ☐ SUN

Current DX — 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 treatment for mental health, chemical dependency or eating disorder (reason for same level of care transfer, if applicable)

I O P

2. Current treatment goals

3. Aftercare plan (provider names, telephone #, appointment date and time)

Current Clinical Presentation

1. Current mental status (substance disorder – date of first use, pattern of use, last date of use, cravings and severity; eating disorder – include height, weight, BMI)

2. Current risk factors (suicidal ideation, homicidal ideation, psychosis, medical, ADLs or current functional impairments that can't be addressed in lower level of care)

3. Progress on treatment goals and barriers to progress

Please complete form in its entirety. Incomplete forms can't 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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