Intensive Outpatient Program (IOP) Request Form

EVERNORTH℠

CLEAR FORM

This form should be completed by the clinician who has a thorough knowledge of the customer's current clinical presentation and his/her treatment history. *Please note: The information contained in this form may be released to the customer or the customer's representative.*

TIPS FOR COMPLETING THIS FORM:

- To help expedite processing of this request, please complete all sections as **specifically** and **clearly** as possible.
- Typed responses are preferred.
- Please do not send encrypted messages.
- Omissions, generalities, and illegibility will result in this request being returned for completion or clarification.

All fields are required unless marked as '*(optional)*'.

Requested start date for treatment, if authorization is granted: _____

Diagnosis (F codes): _____ ☐ **Initial request** **OR** ☐ **Continued Stay request**

1. Customer name: _____ Customer date of birth: _____

ID #: _____ Policyholder Social Security number (SSN) *(optional)*: _____

2. Facility name: _____ Taxpayer Identification Number (TIN): _____

Service address: _____

Utilization Reviewer name: _____ UR phone: _____ Ext.: _____

UR FAX Number *(to Receive Return Faxes)*: _____ Ext.: _____

3. Authorization Request

Previous authorization number *(optional)*: _____ Network Exception Request ☐

Billing Code: ☐ 905 MH IOP/S9480 ☐ 906 CD IOP/H0015 or ☐ Other: _____

CPT Code 90853 does not require authorization, do not submit this form.

Number of visits requested: ☐ 30 ☐ 18 ☐ 12 ☐ Other: _____

Number of visits per week: _____ Number of hours per day: _____

Last substance use date *(optional)*: _____ ☐ N/A *(optional)*: Planned discharge date: _____

Current functional impairment *(optional)*: _____

Aftercare plan *(optional)*: _____

4. Eating disorder IOP ONLY *(optional)*:

Current height: _____ Ideal body weight: _____ Current weight: _____ Body Mass Index (BMI): _____

Eating disorder behaviors/symptoms:

5. Please provide any additional/relevant information (do not attach extra pages) *(optional)*:

6. State Specifics:

Pennsylvania:

Is the treatment facility licensed by the Department of Pennsylvania Insurance AND is there a certification/referral from a physician or psychologist licensed by the Pennsylvania Department of Health?

☐ Yes ☐ No If yes, please submit any supporting documentation if possible.

Please complete this form, save it to your computer, then submit by:

Fax: 1.833.213.9211_(Recommended for more timely response)_**

Email: IOPRequests@Evernorth.com

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