BlueCross BlueShield of Texas

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 BCBSTX at **800-528-7264** to check benefits.

Instructions: For Initial Services, submit completed form through iExchange® or print and fax completed form to BCBSTX at **877-361-7646.**

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)

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 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)

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 _____