IOP INITIAL AUTHORIZATION REQUEST FORM
IOP – IA

To be Completed by OBH				*Revised 2.16.16*
Tracking #		**Date/Time of Receipt**		

PROVIDER INFORMATION			
Provider Company Name			
Person Making Referral		**Credentials**	
Provider Phone #		**Provider Fax #**	
Date of Request		**Provider Email**	
Provider Address			

CLIENT INFORMATION					
Recipient Name				**SS#**	
Age		**DOB**		**Ethnicity**	
Gender		**Gender Expression**		**Marital Status**	
Parent/Guardian				**Phone #**	
Address					

IOP INITIAL AUTHORIZATION REQUEST			
Admit Date		**Requested Length of Stay**	
Requested Start Date		**Requested End Date**	
Last Date Authorized by Magellan (*if applicable*)			
Sessions per week in your IOP program			
Presenting Problem			
Current Diagnosis (Psychiatric/SUD)			
ICD10 Code			
Current Psychotropic Medications			
Medical Diagnosis and Medications			

JUSTIFICATION OF IOP LEVEL OF CARE	
Withdrawal Status: Are the individual's detoxification needs severe enough to require an inpatient/residential level of care? Can the individual's withdrawal symptoms be managed in the community?	
Comment	
Medical Status: Does the individual present with acute (severe) medical problems? Is the individual medically stable to function in IOP? If there are medical needs, can they be managed in the community with supports?	
Comment	
Psychiatric Status: Can the individual's psychiatric symptoms be managed in the community with the appropriate psychiatric supports? Is the individual's cognitive ability sufficient at this time to benefit from admission to IOP? Has the individual demonstrated an ability to develop skills to manage symptoms or make behavioral changes?	
Comment	
Motivation Status: Does the individual demonstrate motivation to comply with the requirements of the treatment for management of symptoms and/or for successful behavioral change?	
Comment	
Relapse Potential Status: Does the individual's condition reflect a pattern of severe substance use as evidenced by periods of inability to maintain abstinence over a consistent period of time?	
Comment	
Community Support Status: Is the individual able to seek professional supports and/or support from caretakers/guardians/family members outside of program hours as needed?	
Comment	
Provide information regarding treatment plan and discharge determination:	
Comment	