UnitedHealthcare
MILITARY & VETERANS

Please fax the completed form to 877-581-1590

Intensive Outpatient Request Form

NOTE: Only hospitals and substance use disorder rehabilitation facilities (SUDRFs), that also provide PHP services, and KEPRO certified freestanding facilities/clinics may perform IOP services. Reimbursement is not available for hospital-based IOPs that are not also PHPs.

☐ Mental Health IOP (S9480) ☐ Substance Abuse IOP (H0015) ☐ Dual Track (MH/SA) IOP (S9480)

Number of IOP hours per day: Number of days per week: Number of requested sessions:

Beneficiary Name: Last, First, MI	Proposed Admission Date: (mm/dd/yyyy)
Beneficiary Address: Street, Apt. No, City, State, Zip Code	Beneficiary/Sponsor ID:

Beneficiary Phone: Home	Beneficiary Phone: Cell	Beneficiary DOB: (mm/dd/yyyy)

Form Completed By: Beneficiary Age:

Other Health Insurance? ☐ Yes ☐ No If yes, specify:

Facility Address: Street City State Zip Code

Facility Name:

Facility Tax ID #:	Facility NPI #:
Facility Phone #:	Fax #:
Attending Physician:	Phone #:
Facility UM Reviewer:	Phone #:

Specify current symptoms and behaviors that require IOP (include what brings the patient to treatment at this time [why now], mental status exam and any risk of harm to self or others):

Specify current functional impairments (describe what responsibilities or activities are currently impaired, e.g. ADLs, work/school performance, etc.):

Past Behavioral Health Treatment History:

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Self-help history: ☐ AA ☐ NA ☐ Other If other:

Past: Frequency of attendance

Sponsor? ☐ Yes ☐ No

Current: Frequency of attendance

Sponsor? ☐ Yes ☐ No

Substance Abuse History:

Substance	Amount used	Frequency	Date of last use	Length of current use/ Length of use

Current Psychotropic Medications:

Medication	Dosage	Scedule	Administration Route	Start Date

DSM-5 Diagnosis:

Relevant medical conditions:

Psychosocial situation (housing, support system, family involvement, work/school, etc.):

Treatment Objectives

Discharge Plans:

Provider Signature Credentials Date

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