Intensive Outpatient Program (IOP)

IOP REQUEST FORM

BlueCross BlueShield of Illinois

This is a request to review if the treatment meets the medical necessity definition under the member's health benefit plan. It does not confirm patient is eligible for benefits.
For Initial Services, the Provider must call BCBSIL at 800-851-7498 to check benefits.
Instructions: Please fill out and print, or print form and fill out legibly in black ink. Fax to BCBSIL at 877-361-7656.

Date_____

Check One:	☐ Initial Request ☐ Concurrent ☐ Discharge	Check One:	☐ CD ☐ MH

Patient Name_____ 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 #_____Fax #_____

Days Per Week (#) _____ Hrs Per Day (#) _____ Sessions Requested (#) _____ Are the total hours per week between 9-20 hrs? ☐ Yes ☐ No

Date Mbr Started IOP _____ Total Days Used (#) _____ IOP Concurrent Start Date _____ IOP End Date _____

Please Indicate DX Preference

DSM	ICD	
IV	9	10

Current Diagnosis

☐☐☐ Code #: _____ DX Name: _____ Dx Specifiers: _____

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Medications

Current Clinical Presentation/Risk Factors (Substance abuse: Include last date of use)

Previous MH/CD Treatment

Current Treatment Goals

Aftercare Plan

Additional clinical information can be faxed with this form it needed.

My signature confirms that I, or the facility I represent, will provide the requested services.

Signature _____ Date _____

I O P

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