

**Intensive Outpatient Program (IOP)  
IOP REQUEST FORM**



**BlueCross BlueShield  
of Oklahoma**

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 BCBSOK at 800-672-2378 to check benefits. Instructions: Please fill out and print, or print form and fill out legibly in black ink. Fax to BCBSOK at 877-361-7660.

Date \_\_\_\_\_

<b>Check One:</b>	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Concurrent	<input type="checkbox"/> Discharge	<b>Check One:</b>	<input type="checkbox"/> CD	<input type="checkbox"/> 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 # _____
Sessions Requested _____	Amount Per Week _____ Total Days Used _____
IOP Start Date _____	IOP Concurrent Date _____ IOP End Date _____

**DSM-IV Diagnosis**

Axis I \_\_\_\_\_  
 Axis II \_\_\_\_\_  
 Axis III \_\_\_\_\_  
 Axis IV \_\_\_\_\_  
 Axis V \_\_\_\_\_

Medications \_\_\_\_\_

Presenting Problem or Current Progress/Risk Factors (Substance abuse: Include last date of use)

Previous MH/CD Treatment

Treatment Goals

Discharge/Aftercare Plan

*Additional clinical information can be faxed with this form if needed.*

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\* I O P \***