KAISER PERMANENTE®

Behavioral Health Service
Mental Health Intensive Outpatient Services
Authorization Request

>> Incomplete forms may delay reauthorization << **>> One form per provider <<**

Please fax completed form to the Behavioral Health Access (BHA) fax number listed below.
BHA Fax: 206-630-1683 / Phone: 206-630-1680 or toll-free 1-888-287-2680
Mailed forms are accepted as well: Kaiser Permanente, BHA, P.O. Box 34799, Seattle WA 98124-1799

Provider Name: _____ **Today's Date:** _____

Agency: _____ **Consumer Name:** _____

Phone Number: _____ **Consumer Number:** _____

Fax Number: _____ **Date of Birth:** _____

Date Current Episode of Care Began: _____

1. **Suicidal/Homicidal Ideation or Thoughts of Serious Self Harm**: Current: ☐ Yes ☐ No Past: ☐ Yes ☐ No

   Current Suicide Plan: ☐ Yes ☐ No Current Suicide Intent: ☐ Yes ☐ No Past Attempts: ☐ Yes ☐ No

   Current Homicide Plan: ☐ Yes ☐ No Current Homicide Intent: ☐ Yes ☐ No Past Attempts: ☐ Yes ☐ No

   *If "Yes" to any Suicidal/Homicidal symptoms, please address in Treatment Plan, below.

2. **Does the patient have an alcohol/substance use problem**? ☐ Yes ☐ No

   Has the patient been referred for treatment? ☐ Yes ☐ Yes, but patient declined ☐ No

3. Functional Impairments: Current impact of symptoms on functioning:

	None	Mild	Moderate	Severe	Response To Treatment*	Description
Social	☐	☐	☐	☐	_____	_____
Psychological	☐	☐	☐	☐	_____	_____
Physical Health / Self Care	☐	☐	☐	☐	_____	_____
Work / School	☐	☐	☐	☐	_____	_____

*Response to Treatment: (I) Improving, (NC) No Change, (D) Declining

4. **Is patient taking psychotropic medication(s)?** ☐ Yes ☐ No ☐ Not Recommended ☐ Pt. Declined

   **If yes, please list the name, address and phone number of the prescribing clinician: _____

   _____

5. **Please list current medications with dosage, duration, and adherence.**

Medication	Dosage	Duration	Medication	Dosage	Duration

6. **Does the patient require 24-hour supervision?** ☐ Yes ☐ No

7. **Can the patient be safely managed at a lower level of care?** ☐ Yes ☐ No

   *If no, please give medical necessity rationale for IOP level of care.

   _____

   _____

   _____

CONFIDENTIAL **This information can be disclosed only with written consent of the person to whom it pertains or is otherwise permitted by such regulations (Uniform Health Information Act Title 70.02)**

Treatment Plan

Please Note: In order for KFHPWA to authorize continuing mental health care, treatment needs to be medically necessary, as determined by review of clinical and treatment information provided/available and Medical Necessity Criteria.

Primary Diagnosis:_____ **Code:**_____

Outline or Describe Associated Symptoms being treated: _____

Duration of Symptoms being treated: ☐ <30 Days ☐ 1-6 Months ☐ 7-12 Months ☐ >1 Year

Current Symptom Severity: ☐ None ☐ Mild ☐ Mild-Mod ☐ Moderate ☐ Mod-Severe ☐ Severe

Goal (Specific and Measurable): _____

_____

_____

As Measured by: _____

Treatment Modality: ☐ Med Mgmt. ☐ CBT ☐ DBT ☐ IPT ☐ Other _____

Current Treatment Interventions to Meet Goal (Specific; Frequency and Duration) _____

_____

Outline Progress towards goal (including any changes in symptoms and response to treatment as measured by the method outlined above) _____

_____

_____

Current Status:

☐ Resolved ☐ Significant Progress ☐ Moderate Progress ☐ Little Progress ☐ No Progress ☐ Declining

If patient is not progressing toward meeting therapeutic goals:

1. Describe reason for lack of progress: _____

_____

_____

2. What changes in treatment (Treatment Modality, Specific, Measurable Goals and Interventions) are being made to help the patient progress in treatment? _____

_____

_____

Secondary Diagnosis:_____ **Code:**_____ ☐ DSM 5 ☐ ICD-10

Outline or Describe Associated Symptoms being treated: _____

Duration of Symptoms being treated: ☐ <30 Days ☐ 1-6 Months ☐ 7-12 Months ☐ >1 Year

Current Symptom Severity: ☐ None ☐ Mild ☐ Mild-Mod ☐ Moderate ☐ Mod-Severe ☐ Severe

Goal (Specific and Measurable): _____

_____

_____

As Measured by: _____

Treatment Modality: ☐ Med Mgmt. ☐ CBT ☐ DBT ☐ IPT ☐ Other _____

Current Treatment Interventions to Meet Goal (Specific; Frequency and Duration) _____

_____

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Outline Progress towards goal (including any changes in symptoms and response to treatment as measured by the method outlined above) _____

_____

_____

Current Status:

☐ Resolved ☐ Significant Progress ☐ Moderate Progress ☐ Little Progress ☐ No Progress ☐ Declining

If patient is not progressing toward meeting therapeutic goals:

1. Describe reason for lack of progress: _____

_____

_____

2. What changes in treatment (Treatment Modality, Specific, Measurable Goals and Interventions) are being made to help the patient progress in treatment? _____

_____

_____

Discharge Plan

1. **What is the expected date of discharge for the patient?** _____
2. **What clinical indicators must be present for the patient to successfully discharge from IOP?**

_____

_____

3. **What is the discharge plan for the member upon completion of the IOP program?**

_____

_____

_____

IOP Program Specifics

Please list the appropriate quantity below regarding specifics of the IOP Program:

_____ days per week

_____ hours per day

_____ group sessions per day

_____ individual sessions per week

_____ psychiatric sessions per week

_____ other

Services Requested

CPT / REV Code	QTY.	Dates