Mental Health-PHP/IOP Concurrent Request

Mental Health-PHP/IOP Concurrent Request Details

Mental Health-PHP/IOP Concurrent Request

Provider/Facility Contact Information

Provider Contact/UR Name:* Provider/UR Phone:* Provider/UR Extension: Provider/UR E-Mail:* Provider/UR Secure Fax Number: Is this a telephonic request? (INTERNAL OPTUM USE ONLY)**

___-___-____

Yes No

Participant Information

Note: Fields in this section do not need to be completed unless there have been changes since last review.

Participant Phone: Participant Address (upon discharge): Does the participant have a legal guardian?

___-___-____

Yes No

Request Details

Level of Care Requested:* Original Admission Date*

__/__/____

Diagnosis and Clinical Update

What current symptoms, risks or impairments require treatment under the requested level of care? Please include current clinical presentation.*

Have there been any changes in the participant's medical or psychiatric diagnosis since admission?**

Yes No

Any additional psychiatric diagnoses that impact current treatment?**

Yes No

Are there any active medical conditions?**

Yes No

Is participant pregnant?**

Yes No

Was substance use a contributing reason for this admission?**

Yes No

Was the participant admitted with either of the following diagnoses:

Cognition Diagnosis and/or age 65+?
◯ Yes ◯ No

Eating Disorder Diagnosis?
◯ Yes ◯ No

Medications

Have there been any changes to the participant's medication since the last review?**
◯ Yes ◯ No

Are there any barriers/issues related to the medication regimen?**
◯ Yes ◯ No

Recovery/Discharge Plan

What specific actions or treatment are planned to address the acute symptoms or behaviors?*

Discharge Plan:*

Barriers to discharge and plans to address them to promote sustained recovery:*

Any relevant information not otherwise discussed that is important to the review of this case.

Confirmation & Attestation

Please note this authorization request is not a guarantee of payment, coverage is still subject to applicable State of Maryland benefits.

I attest all of the information provided is accurate and reflected in the participant's medical record.*
☐

Important:

1) When this form is saved a pop-up box will appear regarding an additional form being recommended.

2) Click Continue to move to the next form, DO NOT click Decline.

3) Do NOT click Cancel or the "X" on the top right of the screen before completing the Data Capture form.

4) After completing the Data Capture form, click Save and you will be returned to the authorization screen.

Data Capture Required:

- Yes