

CIGNA
Mental Health Intensive Outpatient Program Concurrent OR Initial Review Form
PLEASE CHECK IF INITIAL OR CONCURRENT

All Information Requested on This Form Must Be Complete. Missing Data May Result in Authorization Delay

PLEASE PRINT OR TYPE ONLY

Today's Date: _____ Patient's Full Name: _____

Date of Birth: _____ UM # or SS #: _____

Facility/Program Name: _____

Facility Tax ID#: _____

Days/Week: _____ Hours/Day: _____ State: _____ Zip Code: _____ Fax #: _____

Submitting Staff

Name/Credentials: _____ Phone #: _____

Attending MD Name: _____ Phone #: _____

Level of Care (**Please Check One**):

IOP: _____ Phase 1-4 (If contract delineates): _____ Low Intensity IOP: _____ After-Care: _____

Diagnosis With DSM IV Codes: (Include Any Changes**)**

axis I: _____

axis II: _____

axis III: _____

axis IV: _____

axis V: Current _____ Baseline _____

Is there Current Risk of Harm to self or others Yes _____ No _____

If yes explain _____

Client's Current Symptoms:

Describe the current functional impairment (Describe what responsibilities or activities are currently impaired and what role the current symptoms have on the impairment)

How does Client Verbalize his/her Goals of Treatment:

1. _____

2. _____

3. _____

Client's Progress Toward His/Her Treatment Goals (If no progress identify barriers):

1. _____
2. _____
3. _____

Client's Current Medication (Include All Changes**):**

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

The Client currently finds Support from:

Work _____ Friends _____ Community _____
Home _____ Church _____ Legal _____ None _____

Date of Last Family/Support Session: _____ Outcome: _____

If No Family/Support Session, When is One Planned?: _____

Aftercare Plan (Provider Name, Number, and Credentials, with Appointment Date and Time**):**

Therapist: _____

Psychiatrist/PCP/Other Prescribing Physician: _____

Is the client currently overlapping treatment with any outpatient providers while in IOP?: _____

If no would the client benefit from overlapping individual or family therapy while in IOP? _____

Has coordination occurred with above providers? _____

Community Resources _____

Will You Need Assistance With Aftercare Planning? _____

What are the specific behavioral changes that must occur in order for the client to be appropriate for discharge to routine outpatient treatment? (Discharge Criteria)

Continued Authorization, Discharge Planning, and Termination with Patient:

Sessions Authorized To Date: _____ Requested Start Date of New Auth: _____

Additional Sessions Requested: _____ Planned Discharge Date: _____

Patient Aware of Planned Discharge Date: _____ Patient involved in Discharge Planning: _____

****Submission of this form and any subsequent authorization of visits by CIGNA Behavioral Health do not guarantee claims payment. Payment for services rendered is contingent upon the participant's current health benefit eligibility status, copayments, and available mental health/substance abuse benefits. Please note that benefit and/or coverage changes can occur on an account's anniversary date, which is often at the end of the calendar year. If you have any questions regarding your participant's eligibility, please contact CIGNA Behavioral Health at the number on the back of the participant's identification card.** Please fax this form to CIGNA Behavioral Health: (860) 687-7329**

CIGNA
IOP Discharge Summary

PLEASE PRINT OR TYPE ONLY

PATIENT'S NAME: _____

SOCIAL SECURITY # OF CARD-HOLDER: _____

UTILIZATION REVIEW PERSON/COUNSELOR/ CARE MANAGER NAME AND PHONE

FACILITY'S NAME/CIGNA BEHAVIORAL HEALTH PROVIDER#: _____

WAS THIS MH/ OR CD IOP _____

FIVE AXIS DX AT DISCHARGE:

AXIS I _____
AXIS II _____
AXIS III _____
AXIS IV _____
AXIS V _____

OF IOP SESSIONS ATTENDED: _____ D/C DATE IS: __/__/__

THE REASON FOR THE DISCHARGE IS:

___ SUCCESSFULLY COMPLETED TREATMENT

___ BENEFITS EXHAUSTED

___ DROPPED OUT OR NO SHOWED MORE THAN ONCE

___ TRANSITIONING TO ALTERNATIVE LEVEL OF CARE (_____)

MEDS AT D/C: _____

PROGNOSIS: __ EXCELLENT __ GOOD __ FAIR __ POOR

THE FOLLOW UP APPOINTMENTS ARE AS FOLLOWS:

___ MD APPT WITH DR. _____ ON _____ FOR MEDICATION MGT.

___ THERAPIST APPT WITH _____ ON _____ FOR THERAPY

ANY OTHER RECOMMENDATIONS FOR THIS FOLLOW-UP CARE:

PLEASE FAX THIS FORM TO CIGNA : (860) 687-7329

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