BLUE SHIELD OF CALIFORNIA
INTENSIVE OUTPATIENT TREATMENT (IOP) REQUEST
EATING DISORDERS - CONCURRENT REVIEW (CCR)
SEND COMPLETED FORM TO SECURE FAX 1-888-656-0818

Patient name: _____ DOB: _____
Subscriber ID#: _____ Case #: _____
1. Total sessions authorized to date for this admission: ___
2. Sessions authorized based on last review (included in # listed above): ___
3. Date span of sessions authorized in #2 above _____ to _____ **Next review due date**: _____

Magellan accepts verbal or written requests for IOP CCR. This form is provided for ease and convenience to facilitate the concurrent review process. Use of this form will reduce delays resulting from insufficient information.

TO BE COMPLETED BY FACILITY ON OR BEFORE THE "NEXT REVIEW DUE DATE" INDICATED ABOVE:

☐ I attest that the information contained in this treatment request is accurate and supported by the medical record.
Utilization reviewer name: _____ Phone: _____ Fax: _____
Credentials: _____ License number: _____ Date: _____

Number of sessions attended to date for this admission: _____
Days member attends IOP: M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su ☐

Last date attended: _____ Projected discharge date: _____
Are you requesting an extension to the authorization end date? Yes ◯ No ◯ If so, to what date?
Reason for extension:
If you selected "Yes", indicate the reason and date of the extension. No additional information is needed.

Indicate diagnosis codes:
Behavioral:
Medical:

Do you verify that all clinically appropriate assessments have been completed? Yes ◯ No ◯
If no, explain:
What progress has the member made on the symptoms presented upon admission? Include changes in severity and frequency since admission/last review:

Describe any risk factors the member is presenting currently. Include harm to self, harm to others, and threats of violence. Include severity and interventions associated with current risk.

How often are you validating the level of safety for the member?

Provide the member's current height, weight and BMI (include changes since last admission/last review):

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What is the level of supervision required for mealtime and bathroom usage?

What is the member's current caloric meal plan and compliance level with meal plan?

Is the member currently using any type of pharmaceutical assistance with the intent to control their weight?
Yes◯No◯ If so, indicate amount and frequency of use:

Does the member have any medical conditions that are impacting their behavioral health treatment?
Yes◯No◯ If yes, describe:

Describe the member's current support network/system and how they are involved in the member's treatment:

Describe the member's current motivation level for treatment and recovery:

What is the member's current treatment plan specific to the presenting and current symptoms?

Describe any barriers and interventions the member has that are preventing him/her from progressing in their treatment goals:

Has the member been seen by a medical professional/psychiatrist since last review? Yes◯No◯
If yes, provide the date: _____

Medications (include dosage/frequency indicating changes/updates since last review):

Explain reasons the member cannot be managed in an outpatient or community-based program currently:

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Discharge planning:

Indicate the current discharge plan for the member (home with others, home alone, shelter, SLE, outpatient psychiatrist, therapist, PCP):

Include coordination of care that is occurring with other providers involved in the member's care (PCP, therapist, psychiatrist, etc.):

Does the member and/or their support system understand the discharge plan?

Yes ○ No ○ Describe:

If the member is being discharged on medications, has the member been educated on their medications, dosages, regimen and importance of compliance?

Yes ○ No ○ Describe:

What is the main barrier for discharge from IOP currently?

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FINAL DISCHARGE INFORMATION

****SUBMIT THIS PAGE ONLY UPON DISCHARGE****

Utilization reviewer name: _____ Phone: _____
Member name: _____
Member address: _____
Member city: _____ State: _____ Zip: _____
Member phone: Home: _____ Cell: _____

Discharge date: _____
Total number of IOP sessions used: _____

Discharge plan:
Therapist name: _____ Phone: _____
Appointment date and time: _____

MD name: _____ Phone: _____
Appointment date and time: _____

Other referrals and community resources provided at discharge:

Discharge status (completed program/AMA):

Discharge medications:

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