Clear Form

Mental Health Intensive Outpatient Initial Authorization for Out of Network Providers ONLY

For Medica members, please fax completed form to 1-855-454-8155.
Call 1-800-848-8327 for Medica eligibility and benefit questions.

DATES OF SERVICE:

Admit date: Proposed Discharge Date: # of Days per week:

Facility Name: HCPCS/Rev Code:

Facility Address: Tax ID:

Program Name (if different from facility number): Phone & Fax:

Member Name: DOB:

Medica ID# (or SSN#):

Member Address:

Primary Phone #: Mobile #:

Please attach supporting documentation along with this form

1. Current symptoms (within the last 30 days):
   - Description of symptoms – Onset, duration, frequency, intensity/severity of symptoms and conditions under which symptoms occur (e.g. home, school, community), impact of symptoms, developmental concerns that impact symptoms.
2. Behavioral Observations:
   - Presentation, affect, thought processes, activity level, risk assessment, motivation, degree of insight, judgment, level of cooperation, etc.
3. Substance use history
   - Result of chemical dependency screening and referrals as indicated.
4. Past history of problems:
   - Description of symptoms - Onset, duration, frequency, intensity/severity of symptoms and conditions under which symptoms occur (e.g. home, school, community)
5. History of previous mental health/psychiatric treatment:
   - Provider(s) names, dates of services, number of sessions, type of service, frequency, outcome, recommendations, formal testing, medications trials (name, dose, duration, effectiveness, compliance), previous diagnoses.
6. Academic History:
   - Special education services received, EBD placement, intelligence testing results, school behavior, suspensions, truancy, school interventions, academic decline, extra-curricular activities, IEPs
7. Family History:
   - History of mental illness, substance abuse, history of physical/sexual abuse, legal problems, out of home placement(s), marital status of parents/guardian, parental amenability/cooperation with treatment, parenting ability, extended family support.
8. DSM-5: Date, diagnostician (Name, Credentials)

Fax: 1/855-454-8155 or Mail: MN-CAC; P.O. Box 1459; MN 103-0500; MPLS, MN 55440-1459