PerformCARE®

Substance Use Disorder IOP Program Prior Authorization Request and Discharge Form

Telephone: 1-888-700-7370
Submit via Fax: 1-888-987-5828

Requests received prior to 4 p.m. are dated that day.

Member:

Provider:

Member date of birth:

Provider phone #:

MAID# (10 digits):

Provider fax #:

Member's current address:

Provider address:

Member phone:

Date referral complete & member accepted:

Person completing form:

Diagnosis codes (list primary first):

☐ **Co-Occurring (MH/SA)**

☐ **Dual Diagnosis (MH/ID)**

Requested Service:	Start Date	Units	Anticipated Discharge Date
SUD Intensive Outpatient Program (H0015) Individual and Group Therapy		280 Units 4 weeks	

☐ **Initial request** ☐ **Reauthorization request** ☐ **Modifiers requested:** ☐ **HG (Suboxone)** ☐ **HX (Tracking)**

If this is a discharge, complete the following:

Discharge date:

Primary diagnosis at discharge:

ASAM Dimension	LOC Indicated	Criteria indicated and/or comment
Dimension 1: Acute Intoxication or Withdrawal Potential		
Dimension 2: Biomedical Conditions and Complications		
Dimension 3: Emotional/Behavioral/Cognitive		
Dimension 4: Readiness to Change		
Dimension 5: Relapse/Continued Use/Continued Problem Potential		
Dimension 6: Recovery/Living Environment		