PerformCARE®

Substance Use Disorder IOP Program Prior Authorization Request/Discharge Form *for NaviNet Submission Only*

Out of Network (OON) Providers: A detailed rationale for utilizing an OON Provider including why an INN Provider is unable to meet the member's treatment needs must be included with your request.

This form must be uploaded as a supplemental document to the NaviNet Provider Portal Authorization process.

Member Name: _____DOB:_____ MAID: _____

REL/SOGI (Complete each section and indicate if Member preferred not to answer).

Member's Race:_____ Member's Ethnicity:_____

Member's Sexual Orientation: _____ Member's Gender Identity:_____

Member's Assigned Sex at Birth:_____ Member's Pronouns: _____

Member's Alternative Name (if applicable): _____

Member's Primary Language:

Written: _____ Spoken: _____

Provider Information

Provider Contact: _____

Provider Phone #: _____ Provider Fax #: _____

Date Referral Complete/Member Accepted: _____

Authorization

☐ Initial Request ☐ Reauthorization Request

*This form is to be uploaded as part of the NaviNet Authorization process
Capital Members: 1-888-722-8646 Franklin/Fulton Members: 1-866-773-7917
Providers: 1-888-700-7370
Mailing Address: 8040 Carlson Road, Harrisburg, PA 17112

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☐ Discharge (Date/Primary Diagnosis at discharge: _____)

Code	Description	Start Date	Units	Anticipated Discharge Date
H0015	SUD Intensive Outpatient Program ☐ HG (Suboxone) ☐ HX (Tracking)		1976 (6 mos)	

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		

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