PerformCARE®

Substance Use Disorder IOP Program Prior Authorization Request/Discharge Form

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.

Member Information

Member Name: ___________________________________ MAID: ___________________ DOB: ________

Member Address: ____ Phone #: ____________

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 Name for Authorization: ____

Provider Address: ____

Provider Phone #: _________________________ Provider Fax #: _______________________

Provider Contact: ____

Date Referral Complete/Member Accepted: _______________________________

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Authorization

☐ Initial Request ☐ Reauthorization Request

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

Diagnosis codes: _____________________ ☐ Co-Occurring (MH/SUD) ☐ Dual Diagnosis (MH/ID)

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		