BlueCross BlueShield of North Carolina

Use for Commercial Members (including State Health Plan)
Submit as attachment via Blue E Authorization Portal or Fax to 866-987-4161

Intensive Outpatient Program (IOP) Authorization Request

AUTHORIZATION REQUEST

Submission of this form is only a request for services and does not guarantee approval; not all Blue Cross NC plans provide benefit coverage for IOP. Incomplete forms may delay processing.
All NC Providers must provide their 5-digit Blue Cross Blue Shield of North Carolina (Blue Cross NC) provider ID# below.

Intensive Outpatient Programs (IOP) provide time-limited, multidisciplinary, multimodal structured treatment for chemical dependency or psychiatric disorders in an outpatient setting. IOP is intended to provide treatment on an outpatient basis, does not include boarding/housing and is intended to provide treatment interventions in a structured setting, with patients returning to their home environments or a community-based setting each day. IOP does not include treatment in a locked unit or restricted access setting.

Date of Request	Patient Name	Patient Date of Birth
Patient Blue Cross NC ID Number	**Patient Current Address (residence at time of service)**	**Program Network Status and Local BCBS plan ID**

Servicing Provider Information + Address of location member will attend		Supervising Provider (if applicable)	
Provider Name		Provider Name	
Provider PPN#, Tax ID # or NPI		Provider PPN#, Tax ID # or NPI	
Street, Bldg., Suite #		Street, Bldg., Suite #	
City/State/Zip code		City/State/Zip code	
Phone #		Phone #	
Fax #		Fax #	

Current DX – Please list ICD-10 codes(s), Diagnosis Name, Specifier (if applicable)

ICD-10 Code ____________ DX Name ______________________________________ Specifier ___________________________
ICD-10 Code ____________ DX Name ______________________________________ Specifier ___________________________
ICD-10 Code ____________ DX Name ______________________________________ Specifier ___________________________

PLEASE SUBMIT COPY OF CURRENT LICENSURE FOR REVIEW WITH INITIAL REQUEST

Authorization Request type (check One)	☐ Initial Treatment Request ☐ Extension of Treatment Request. Please provide previous reference/authorization approval #: ____________

Place of Service	☐ Office ☐ Clinic ☐ Outpatient ☐ Other_ Blue Cross North Carolina will only reimburse for IOP in a community-based setting		
Requested Treatment Start Date		Anticipated End Date	
# of days per week		# of hours per day	
Treatment Days of the Week (circle each)	M T W Th F Sa Su	Name of Supervising Psychiatrist and date of evaluation	
CPT (Procedure Code) and Units	☐ H0015 (SUD) (BCBSNC does not reimburse unbundled codes for IOP) ☐ S9480 (Psych) (BCBSNC does not reimburse unbundled codes for IOP) *Only one (1) unit for IOP on a facility or professional claim, is allowed per date of service as these services are defined as per diem.* *IOP is allowed on facility or professional claims as a per diem and includes all facility, professional, ancillary, and other services rendered to the member at the site.*		

II

**** For Initial Authorization Requests Only ****

Approval must be obtained in advance of admission – failure to do so may result in reimbursement denial

SUD requests must include:	Psychiatric IOP requests must include:
✓ Serial vital signs and withdrawal scale scores from prior 72 hours for SUD ✓ Drug Screen and relevant Lab Results ✓ Documentation supporting the member and/or family member has been made aware of FDA approved Medication Assisted Treatments (MAT) available. The facility should document informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT treatment.	✓ Standard rating scales for psychiatric service requests Treatment plans ✓ Medication review ✓ There is documentation of a safety plan including access for the member and/or family/support system to professional support outside of program hours.

Pertinent Medical History (active co-occurring conditions)	
Current Medications (dosages, duration)	☐ Please indicate if including as a separate attachment if necessary.
Scales and Assessments	

Treatment Plan	
Treatment History	Please provide details related to prior treatment history and response, including service category type (i.e., Inpatient, Residential Treatment, Partial Hospitalization, Intensive Outpatient Program, regular outpatient therapy). ☐ Please indicate if including as a separate attachment if necessary.

By signing below, I certify that I have appropriate authority to request prior authorization and certification for the item(s) indicated on this request and that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in the patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available. Finally, I certify that I've completed this form in its entirety and I understand that an incomplete form may delay processing.

Signature:____Date: __________________

Submit this form as an attachment via the Blue E Authorization Portal with required documentation.

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