



**MERCY MANAGED BEHAVIORAL HEALTH**  
**Intensive Outpatient Request Form (IOP)**

Request Date: \_\_\_\_\_

Check One:	<input type="checkbox"/> Initial Request <input type="checkbox"/> Concurrent <input type="checkbox"/> Discharge	Check One:	<input type="checkbox"/> SUD <input type="checkbox"/> MH
Patient Name: _____ Plan Name: _____		DOB: _____ Insurance ID #: _____	

Facility Name: _____	TIN: _____	NPI: _____
Address: _____	City: _____	State _____ Zip _____
Attending Physician: _____	MD TIN: _____	MD NPI: _____
<input type="checkbox"/> Check here if address is same as facility	Address: _____	City: _____ State _____ Zip _____
UR/Contact Name: _____	P: _____	F: _____
Start Date of Current Request: _____	IOP End Date: _____	
Total Days Requested: _____	# Days Per Week: _____	

**Current Diagnosis**

Code: \_\_\_\_\_ Diagnosis Description: \_\_\_\_\_

Code: \_\_\_\_\_ Diagnosis Description: \_\_\_\_\_

Code: \_\_\_\_\_ Diagnosis Description: \_\_\_\_\_

Code: \_\_\_\_\_ Diagnosis Description: \_\_\_\_\_

Psychosocial Supports: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Outpatient Providers: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Clinical Criteria Information:**

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1. Current Mental Status: *include symptom severity, duration, and any functional impairments. For SUD include usage summary at initial request and progress with relapse prevention plan at concurrent requests. For Eating Disorder include HT, WT, BMI, % IBW, and vitals in addition to current symptom presentation.*

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2. Risk Factors: *include SI, HI, Psychosis, Psychosocial, or Medical*

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3. Medications: *include dosages and frequency*

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4. Diagnostic Findings (PHQ-9, COWS, CIWA):

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5. Previous MH/CD Treatment: *needed at initial request only*

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6. Current Treatment Goals/Progress Since Last Review:

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7. Aftercare/Discharge Plan:

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By signing below you are confirming that the information you have provided on this form is accurate and complete based on your clinical assessment of the patient.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Fax completed forms to Mercy Managed Behavioral Health at 314-729-4636. Additional clinical information can be faxed with this form if needed.*