



HEALTH SERVICES
REVIEW OF TREATMENT

PacificSource
HEALTH PLANS

**CHEMICAL DEPENDENCY OUTPATIENT AND INTENSIVE OUTPATIENT (IOP)
TREATMENT PLAN — REQUEST FOR DETERMINATION OF MEDICAL NECESSITY**

PATIENT INFORMATION

Name: _____ DOB: ___/___/___ PacificSource ID: _____

PRACTITIONER INFORMATION

Name: _____ License type: _____ Tax ID Number: _____

Address: _____

City/State: _____ Phone: _____ Fax: _____

Case Manager: _____

TREATMENT INFORMATION

DSM IV: _____ Disorder: _____ (Please include DSM IV code and name of disorder.)

Is this a court-mandated diversion program? Yes No

- ASAM Level:
- Dimension 1: Detox/withdrawal potential
 - Dimension 2: Physical health risks/complications
 - Dimension 3: Emotional, behavioral, cognitive conditions/complications
 - Dimension 4: Readiness to change
 - Dimension 5: Relapse, continued use, or continued problem potential
 - Dimension 6: Recovery/living environment

Case summary: (Identify the problems and priorities that determine the proposed level of care.) **Attach initial evaluation with case history and clinical impression.**

TREATMENT RECOMMENDATION

- Adult Level 1: Outpatient
- Adolescent Level 2: Intensive outpatient (IOP)

____ Group(s) per week + ____ Hour(s) of individual/family treatment per week = _____ visits

____ Hours per group **____ Total individual/family treatment hours/week**

____ Total Group Hours/week

Time Frame: ___/___/___ to ___/___/___ Total number of visits proposed: _____

CONTACT INFORMATION

Contact person/clinic/provider: _____

Date: ___/___/___ Phone: _____ Fax: _____

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