CIGNA
Substance Abuse Intensive Outpatient Program Concurrent/ Initial ReviewForm
PLEASE CHECK IF INITIAL OR CONCURRENT

All Information Requested on This Form Must Be Complete. Missing Data May Result in Authorization Delay . There is no authorization guarantee for retrospective authorization requests.

PLEASE PRINT OR TYPE ONLY

Today's Date: ______________________ **Patient's Full Name:** __________________________

Date of Birth: ______________________ **UM # or SS #:** ___________________________

Facility/Program Name: ____

Facility Tax ID #:_________________________________

Days/Week: ____ **Hours/Day:** ____ **State:** ____ **Zip Code:** _________ **Fax #:** __________________
Submitting Staff
Name/Credentials: _________________________________ **Phone #:** _______________________

Level of Care (Please Check One**):**
IOP: _____ **Phase 1-4 (If contract delineates):** _____ **Low Intensity IOP:** _____ **After-Care:** _____

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Diagnosis With DSM IV Codes: (Include Any Changes and Please Use DSM-IV Codes**)**

axis I: ____________

axis II: ____________

axis III: ____

axis IV: ____

axis V: ____________ **MH assessment completed:** ____ **Outline the plan to address any MH issues:**
____

The client's current Stage of Engagement in substance abuse treatment (Place "X" on Correct Line):
Pre-Contemplation: _____ **(Patient is not yet considering Change)**
Contemplation: _____ **(Patient is ambivalently weighing the pros and cons of change)**
Determination/Preparation: _____ **(Patient makes a beginning commitment to the change process)**
Action: _____ **(Patient is taking specific steps toward accomplishing change)**
Maintenance: _____ **(Patient is maintaining the changes made)**
Relapse: _____ **(Patient temporarily returns to pre-change behaviors)**

Outline plan to engage internal/external motivators to gain commitment to next Stage of Engagement
____
____

Patient's Current Status ("Y" or "N"):
____ **The Client is attending a 12 Step Program?**
____ **The Client is connected with a 12 Step "Sponsor"?**
____ **Have External Motivators (work, church, legal, family, friends) been involved in treatment?**

If "No", when are you planning for them to be? ____________________
____ **Have Relapse Triggers been identified?**
____ **Is the Client Actively working a Relapse Prevention Plan?**

____ Are outreach attempts made to assess and engage the client when there is a "no show"?
____ Is the program utilizing Urine Drug Screens?

__________ The Client has remained Clean/Sober since?
The client's "ends" (reasons for wanting sobriety) are? ______________________________________

____

<u>Current Medication (Include All Changes**):</u>**

1. _________________________ **2.** _________________________ **3.** ___________________________

<u>Patient's Supports (Work, Home, Friends, Church, Community, and/or Legal):</u>

Date of Last Family/Support Session: _______________ **Outcome:** _____________________________

____

If No Family/Support Session, When is One Planned?: ____________________

<u>Aftercare Plan (Provider Name, Number, Credentials, Appointment Date, and Time**):</u>**

____

____

Will You Need Assistance With Aftercare Planning? ________

<u>Continued Authorization, Discharge Planning, and Termination with Patient:</u>

Sessions Attended To Date: ________ **Requested Start Date of New Auth:** ______________________

Additional Sessions Requested: ________ **Planned Discharge Date:** _______________

Patient Aware of Planned Discharge Date: _______ **Patient involved in Discharge Planning:** _______

****Submission of this form and any subsequent authorization of visits by CIGNA Behavioral Health do not guarantee claims payment. Payment for services rendered is contingent upon the participant's current health benefit eligibility status, co payments, and available mental health/substance abuse benefits. Please note that benefit and/or coverage changes can occur on an account's anniversary date, which is often at the end of the calendar year. If you have any questions regarding your participant's eligibility, please contact CIGNA Behavioral Health at the number on the back of the participant's identification card.****
Please fax this form to CIGNA Behavioral Health: (860) 687-7329

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****FOR CIGNA BEHAVIORAL HEALTH USE ONLY BELOW THIS LINE****

Adult / Child **# Sessions**
LOCG Page: ______ - ______ **Authed:** _________ **Start Date of Auth:** ________________________
Follow Up Questions for Next Review:

1. ____

2. ____

3. ____
Next Review Date: ______________ **CM Name/Credentials:** _________________________________

CIGNA
IOP Discharge Summary

PLEASE PRINT OR TYPE ONLY

PATIENT'S NAME: ____

SOCIAL SECURITY # OF CARD-HOLDER: ____

UTILIZATION REVIEW PERSON/COUNSELOR/ CARE MANAGER NAME AND PHONE #____

FACILITY'S NAME/CIGNA BEHAVIORAL HEALTH PROVIDER#: __________________________

____

WAS THIS MH/ OR CD IOP ______

FIVE AXIS DX AT DISCHARGE:

AXIS I ____
AXIS II ____
AXIS III ____
AXIS IV ____
AXIS V ____

OF IOP SESSIONS ATTENDED: _____ D/C DATE IS: __/__/__

THE REASON FOR THE DISCHARGE IS:

____ SUCCESSFULLY COMPLETED TREATMENT

____ BENEFITS EXHAUSTED

____ DROPPED OUT OR NO SHOWED MORE THAN ONCE

____ TRANSITIONING TO ALTERNATIVE LEVEL OF CARE (________)

MEDS AT D/C: ____

PROGNOSIS: __ EXCELLENT __ GOOD __ FAIR __ POOR

THE FOLLOW UP APPOINTMENTS ARE AS FOLLOWS:

__ MD APPT WITH DR.__________________ ON ________ FOR MEDICATION MGT.

__ THERAPIST APPT WITH ______________ ON ________ FOR THERAPY

ANY OTHER RECOMMENDATIONS FOR THIS FOLLOW-UP CARE: ____

PLEASE FAX THIS FORM TO CIGNA : (860) 687-7329

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