



Dialectical Behavior Therapy (DBT) Intensive Outpatient Program (IOP) Prior Authorization Request Form

FAX TO: BHP 763-486-4437 MMSI 1-888-889-7822

*UCare covers Intensive Outpatient DBT services in accordance with DHS guidelines. Please refer to DHS Bulletin #11-53-03.

Request date: _____

Member Name: _____

DOB: _____ UCare ID: _____

Provider of Service: _____

NPI Number: _____

Provider Contact Name: _____

Provider Phone: _____ Provider Fax: _____

Diagnosis: AXIS I AXIS II AXIS III

AXIS IV AXIS V

Number of units/visits requested (Procedure Code H2019):

Individual DBT Therapy (UI, HN): _____

DBT Skills Group (UI, HQ, HN) _____

Requested Start Date: _____ End Date: _____

If exclusionary services (such as partial hospitalization, outpatient psychotherapy, or inpatient hospital) are provided concurrently, please provide rationale:

Please attach the most recent diagnostic assessment, functional assessment, commitment contract, treatment plan, LOCUS (if available) and any supporting documentation to support medical necessity for service requested