CBH INTENSIVE OUTPATIENT (D&A) SERVICE REQUEST FORM

Type of Service: D&A IOP ☐

Provider Number: _____

Date of Submission: _____

Date CBH Received: _____

Client Name	CIS#	Soc. Sec.#	Living Arngm t Code	Voc. Educ. Code	Requested Service Code for IOP	Initial Service Start Date	Requested Auth. Service Start Date	Requested Auth. Service End Date	# of Units (Hours Per Week)	Prim. Axis I Dx	Sec. Axis I Dx	Priority Group Code

Provider Contact: _____

Provider Fax: _____