



INITIAL OUTPATIENT TREATMENT REPORT (IOTR)

Virginia Premier Health Plan, Inc

Contact us:

P.O. Box 5307 Richmond, VA 23220

Fax to Medical Management: 1-800-827-7192

For Medical Management questions call toll free: 1-888-251-3063

All other questions call toll free: 1-800-727-7536

Patient Demographics:

Name: _____ DOB: _____ Medicaid# _____

Date(s) of TX since last OTR: _____

Please check all that apply for the member.

Behavioral Health

Requested # of Visits

Requested Start Date

Diagnosis _____

Please check all that apply for the member.

Substance Abuse

Requested # of Visits

Requested Start Date

Diagnosis _____

Clinician/Therapist Name & Title: _____

(please print)

(signature)

Provider Group or Agency: _____

Provider's Address: _____

(#)

(Street)

(City)

(State)

(Zip)

Provider's Phone: _____

()

(area code)

(phone #)

Provider's Fax: _____

()

(area code)

(phone #)

DO NOT WRITE BELOW THIS LINE: VPHP USE ONLY

Approved _____

visits

Authorization Number _____

Date Range _____

Total Visits Approved Year To Date _____

Additional Visits Requested/Require OTR _____