



INITIAL OUTPATIENT TREATMENT REPORT (IOTR)

Virginia Premier Health Plan, Inc.
Richmond/Western: PO Box 5307 Richmond, VA 23220-0307 Fax 804-819-1727 or 877-689-2276
Roanoke: PO Box 1751 Roanoke, VA 24008-1751 Fax 540-344-8007 or 800-827-7192
Tidewater: PO Box 62347 Virginia Beach, VA 23466 Fax 757-466-1133

Patient Demographics:

Name: _____ DOB: _____ Medicaid# _____

Date(s) of TX since last OTR: _____

Please check all that apply for the member.

	<u>Requested # of Visits</u>	<u>Requested Start Date</u>
<input type="checkbox"/> Behavioral Health	_____	_____
Diagnosis _____	_____	_____

Please check all that apply for the member.

	<u>Requested # of Visits</u>	<u>Requested Start Date</u>
<input type="checkbox"/> Substance Abuse	_____	_____
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