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.

		Requested # of Visits	Requested Start Date
____	**Behavioral Health**	____________	____________
	Diagnosis ________________________		

Please check all that apply for the member.

		Requested # of Visits	Requested Start Date
____	**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

Revised 7/31/13