Tennessee IOP Request Form

For Behavioral Providers

To file electronically, providers in Tennessee must register for access to the online prior authorization tool:

To file via facsimile send to:
1.833.213.9211 (*Recommended for more timely response)*

To file via email send to:
IOPRequests@Evernorth.com

To initiate registration, send an email to PMAC@Cigna.com and include the following information:

- **Provider or facility name**
- **Mailing address**
- **Email address**
- **Contact name**
- **Contact telephone number**

Authorization for Intensive Outpatient is not routinely required please contact Evernorth Behavioral Health for account specific information.

IOP Request Form - TENNESSEE

EVERNORTH℠

CLEAR FORM

This form should be completed by the clinician who has a thorough knowledge of the Evernorth customer's current clinical presentation and his/her treatment history. *Please note: The information contained in this form may be released to the customer or the customer's representative.*

TIPS FOR COMPLETING THIS FORM:

- To help expedite processing of this request, please complete all sections as **specifically** and **clearly** as possible.
- Typed responses are preferred.
- Please do not send encrypted messages.
- Omissions, generalities, and illegibility will result in this request being returned for completion or clarification.

All fields are required unless marked as '*(optional)*'.

Requested start date for treatment, if authorization is granted: _____

Diagnosis (F codes): _____ ☐ **Initial request** **OR** ☐ **Continued Stay request**

1. Customer name: _____ Customer date of birth: _____

Evernorth ID #: _____ Policyholder Social Security number (SSN) *(optional)*: _____

2. Facility name: _____ Taxpayer Identification Number (TIN): _____

Service address: _____

Utilization Reviewer name: _____ UR phone: _____ Ext.: _____

UR FAX Number *(to Receive Return Faxes)*: _____ Ext.: _____

3. Authorization Request

Previous authorization number *(optional)*: _____ Network Exception Request ☐

Billing Code: ☐ 905 MH IOP/S9480 ☐ 906 CD IOP/H0015 or ☐ Other: _____

CPT Code 90853 does not require authorization, do not submit this form.

Number of visits requested: ☐ 30 ☐ 18 ☐ 12 ☐ Other: _____

Number of visits per week: _____ Number of hours per day: _____

Last substance use date *(optional)*: _____ ☐ N/A *(optional)*: Planned discharge date: _____

Current functional impairment *(optional)*: _____

Aftercare plan *(optional)*: _____

4. Eating disorder IOP ONLY *(optional)*:

Current height: _____ Ideal body weight: _____ Current weight: _____ Body Mass Index (BMI): _____

Eating disorder behaviors/symptoms:

5. Please provide any additional/relevant information (do not attach extra pages) *(optional)*:

"Evernorth Behavioral Health" refers to Evernorth Behavioral Health, Inc. and subsidiaries of Evernorth Behavioral Health, Inc., including Evernorth Behavioral Health of California, Inc., and Evernorth Behavioral Health of Texas.

** Please note that Evernorth assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information. It is your responsibility to take any steps necessary to protect the email or documents prior to receipt by Evernorth.

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