*Complete this form in its entirety.**Each field is important for review and processing an out-of-network service request.*  ***Along with this form, complete the appropriate authorization request form. Fax both forms to 1-888-656-2586.***

**Member Information**

Is this member currently placed through the Idaho Department of Health and Welfare or Juvenile Probation?

[ ]  Yes [ ]  No

**Member Name:**      **Member DOB:**

**Address:**

**Magellan Member ID or Medicaid ID:**

**Member Diagnoses:**

**Parent/Guardian Information** (*enter only if member is a child/adolescent)*

**Parent/Guardian Name:**

**Current Full Address** (if different than member)**:**

**Request Rationale**

Why are you requesting out-of-network services?

Service Description, Procedure/Service Code, Modifiers (if applicable) and Number of Units:

If Medicaid member, is the type of service or level of care being requested one that is typically a benefit of the member’s Medicaid plan?

[ ]  Yes [ ]  No

**Facility/Provider Information**

**Name** (requesting out-of-network services):

**Address** (where services will be rendered):

Billing Address (if different):

**Main Phone Number:**

**Tax ID:**       **NPI:**

**Magellan Provider ID/MIS** (if known):

**Requestor Information**

**Name of Person Completing this Form:**       **Phone Number:**

**Email Address:**

**Name of Person to Contact with Questions:**       **Phone Number:**

**Email Address:**

**Name of Person Who will Sign the Single Case Agreement:**       **Phone Number:**

**Email Address:**