***Complete this form and submit via Magellan’s authorizations system, accessed in Availity Essentials***

***(Magellan Healthcare IDAHO Payer Space > Authorizations tile) or fax to 1-888-656-2586.***

**Today’s Date:**

**Level of Care Requested** *(select all that apply)*

Inpatient Hospital  Partial Hospitalization  ASAM Level

**Substance Use Disorder Level of Care Requested (if applicable)**

ASAM Level:

**Partial Hospitalization Frequency of Program Requested**

Days per Week:

**Member Information**

Member Name:       Member DOB:

Member Address:

Member ID:       Member Phone Number:

Primary Spoken Language:

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

Parent/Guardian Name:

Parent/Guardian Phone Number:

**Utilization Review**

Utilization Reviewer (UR) Name:      

UR Phone Number:       UR Fax Number:      

Admission Date:        Voluntary  Involuntary Court Date (if admission involuntary):      

**Facility Information**

Admitting Facility Name:      

Facility Tax ID:      Facility MIS (Magellan ID#), if known or N/A):      

Facility Main Phone Number (or unit phone number):      

Attending Physician First and Last Name:      

Attending Physician Phone Number:       Attending Physician NPI:      

Discharge Planner Name:      

Discharge Planner Phone Number:      

**Clinical Presentation**

Diagnoses (psychiatric, chemical dependency, and medical):      

In the last 24 to 48 hours has the member experienced any of the following?

Suicidal ideation with plan  Suicidal ideation without plan  Suicide attempt

Homicidal ideation with plan  Homicidal ideation without plan  Homicidal attempt

Delusions  Visual hallucinations  Auditory hallucinations  Tactile hallucinations

Command hallucinations

*Detail any attempts, plans/means, and specifics to hallucinations and delusions:*      

Does the member have difficulty with any of the following?

Sleep  Performing ADLs  Impulse control

*If for substance use disorders, detail all substances used (amount, frequency, and date of last use):*

*Detail the clinical rationale for substance use disorder:*

**Treatment and Discharge Planning**

Current and Previous Treatment (level of care, dates, contact information):      

Current Treatment Plan (goals, objectives, progress):      

Is the member attending groups?  Yes  No

Standing Medication (for behavioral and physical health, including name, dose, frequency and medication changes):

Is the member compliant with medication?  Yes  No

PRN Medications Administered (name, dose and date administered):      

Social Support (family, community agencies, etc.):      

Family or Supports Involved in Treatment:  Yes  No

Planned Discharge Level of Care *(include housing, mental health treatment and substance use disorder treatment, if applicable)*:      

*If recent readmission, indicate what is different about the plan from the previous plan(s):*      

Barriers to Discharge:      

Days Requested:       Estimated/Expected Discharge Date:      

**Requestor Information**

Request Submitted By:       Phone Number: