***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: