***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** (s*elect 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:

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

**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:      

**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):      

*Detail precipitant to admission (risk of harm to self, risk of harm to others, psychosis):*      

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

*Detail the clinical rationale for substance use disorder:*

**Treatment and Discharge Planning**

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

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

Current Treatment Plan (goals/objectives):      

Amount, Duration and Frequency (of current service being requested):     

Medications (at time of admission, including type, dose, and/or frequency, and any PRN medication administered):      

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:

**Inpatient/Residential Behavioral Health and Substance Use Disorder Requests**

*Submit the following documentation:*

* Complete Inpatient Treatment Request Form
* Comprehensive Diagnostic Assessment and/or ASAM Evaluation
* Recent Child and Adolescent Needs and Strengths (CANS) Assessment within the last 90 days or other applicable functional assessment
* Psychological/Neuropsychological Assessment if available
* Progress/case notes demonstrating behaviors and all behavioral health services received for previous six months

*If a youth (through the month of their 21st birthday) needs medically necessary services that are not covered under the Idaho Behavioral Health Plan (IBHP), see IDAPA 16.03.09.880. Additional services may be approved through the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, 42 CFR § 440.345.*