***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:**

**Member Information**

Member Name:       Member DOB:

Member Address:

Member ID:       Member Phone Number:

Primary Spoken Language:

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

Parent/Guardian Name:

Parent/Guardian Phone Number:

**Provider Information**

Servicing Provider:

Tax ID:

Servicing Provider Phone Number:       Servicing Provider Fax Number:

**Outpatient Care**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Start Date** | **Stop Date** | **Procedure/Service Code** | **Modifiers** | **Service Description** | **Units** |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |

*Detail why the service is being requested now:*

Diagnoses (psychiatric, chemical dependency and medical):

Current Medications (type, dose, and/or frequency):

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

Impairments (in relationships, school, employment):

Current and Previous Treatment (level of care, dates, etc.):

Current Treatment Plan (goals/objectives):

Expected Outcome(s) from Treatment:

Discharge Plan and Estimated Discharge Date:

***NOTE****: You must submit any/all clinical information to support the medical necessity review.*

**Requestor Information**

Request Submitted By:       Phone Number:

**Outpatient Services**

*Submit the following documentation:*

* Completed Outpatient Authorization Request Form
* Comprehensive Diagnostic Assessment and/or ASAM Evaluation
* Recent Child and Adolescent Needs and Strengths Assessment (CANS) or applicable functional assessment.
* Additional clinical information supporting the request, such as recent treatment records or testing results.

*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.*