Magellan HEALTHCARE

Inpatient Authorization Request Form

Please ensure this form is fully completed before submission. Incomplete forms will not be accepted. Submit the completed form through Magellan's authorization system in Availity Essentials (Magellan Healthcare Idaho Payer Space> Authorizations tile) or fax it to **1-888-656-2586.**

***Fields marked with an asterisk (*) are required**

Member Information			Provider Information		
*Member Name:			*Provider Name:		
*Member ID:			*TIN#:	*MIS or NPI#:	
*Date of Birth:			*Office Phone:		
*Phone:	*Language:		Office Fax:		
*Street Address:			*Office Street Address:		
*City:	*State:	*ZIP Code:	*City:	*State:	*ZIP Code:
*Parent/Guardian Name:					
*Parent/Guardian Phone Number:					

Requester Information			
*Request Submitted by:		Date:	
*Requestor's Email:		Phone#:	
*If SUD Services are provided, I attest that the appropriate SUPRT forms were completed		YES ☐ NO ☐	NA ☐

*Level of Care Requested			
Inpatient Psychiatric Hospital: Initial ☐ Concurrent ☐		ASAM 4.0: Initial ☐ Concurrent ☐	ASAM 3.7: Initial ☐ Concurrent ☐
Admission Date:		Voluntary Admission ☐	Involuntary Admission ☐
Dates of Service Requested	From Date:	To Date:	Total # Days:

Clinical Information
Diagnoses (psychiatric, chemical dependency, medical):
ICD-10 Code(s):

Admitting Facility Information		
***Admitting Facility Name:**	***Facility TIN:**	***Facility MIS/NPI:**
***Admitting Facility Address:**		
***Admitting Facility Phone Number:**		
***Attending Physician Name:**		
Current medications *(Please specify ALL medication(s) including type, dose and/or frequency)*		
Describe current and previous treatment *(level of care, dates of service, etc)*		
Describe barriers to discharge		
***Planned discharge level of care**		***Estimated discharge date**

Additional information that may be important for this review

Please note: The form **must be fully completed** in order for an authorization to be complete. If any required information is missing, we will be unable to proceed, and a member of our clinical team will contact you by phone or email to request that the form be resubmitted with all necessary details. The review turnaround time will not begin until a fully completed form has been received.

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.

For Inpatient Services please submit the following documentation (if available:

- 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