

Outpatient 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**.

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 <input type="checkbox"/>	NO <input type="checkbox"/>	NA <input type="checkbox"/>
Clinical Information							
*Diagnoses (psychiatric, chemical dependency, medical):							
ICD-10 Code(s):							
Outpatient Services							
*Start Date	*Stop Date	*Procedure/Service Code	*Modifier	*Service Description	*Units		
Current medications? (Please specify ALL medication(s) including type, dose and/or frequency)							
Describe social supports (Please include family, community, etc)							
Describe any impairments (Please include relationships, school, employment)							
Describe current and previous treatment (level of care, dates of service, etc)							

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 Outpatient Services please submit the following documentation (if available):

- 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.