

## Residential 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), fax it to 1-888-656-2586, or securely email to [ibhpcinical@magellanhealth.com](mailto:ibhpcinical@magellanhealth.com).

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

Member Information			Custodian Information		
*Member Name:			*Custodian (biological parents, adoptive parents, IDHW, other agency):		
*Member ID:					
*Date of Birth:			*Custodian Name:		
*Phone:	*Language:		*Custodian Phone:		
*Street Address:			*Custodian Address:		
*City:	*State:	*Zip Code:	*City:	*State:	*ZIP Code:
Requester Information					
*Request Submitted by:				Date:	
*Requestor's Email:				Phone#:	
*Level of Care Requested					
<b>Psychiatric Residential Treatment Facility</b> Initial <input type="checkbox"/> Concurrent <input type="checkbox"/>		<b>Residential Treatment Center</b> Initial <input type="checkbox"/> Concurrent <input type="checkbox"/>			
Requested Admission Date:					
Dates of Service Requested	From Date:		To Date:		Total # Days:
Admitting Facility Information					
*Admitting Facility Name:			*Facility TIN:		*Facility MIS/NPI:
*Admitting Facility Address:					
*Admitting Facility Phone Number:					
*Attending Physician Name:					
Clinical Information					
*Diagnoses (psychiatric, chemical dependency, medical):					
ICD-10 Code(s):					
Current medication(s)? <i>(Please specify ALL medication(s) including type, dose and/or frequency)</i>					
Reason for Residential Treatment Request <i>(check all that apply and that are current or within the last 30 days):</i>					
<input type="checkbox"/> Self-harming behaviors	<input type="checkbox"/> Suicidal behaviors	<input type="checkbox"/> Physical aggression			
<input type="checkbox"/> Substance use	<input type="checkbox"/> Psychosis	<input type="checkbox"/> Runaway			
<input type="checkbox"/> Danger to others	<input type="checkbox"/> Other:				



### **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.

*Attach the following documents (if available):*

- Most recent psychiatric and/or psychosocial assessment
- Child and Adolescent Needs and Strengths (CANS) assessment
- Comprehensive Diagnostic Assessment (CDA)
- Court order for treatment (if applicable)
- Individualized education plan (IEP) or 504
- Recent progress notes from current service providers
- Psychological or neuropsychological completed within the last 12 months

*If a youth (through the month of their 21<sup>st</sup> 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.*