OPTUM®

OPTUM IDAHO EPSDT PRIOR AUTHORIZATION REQUEST FORM

Received Date:	Authorized: Y N	PA Number:

STEP #1 – Provide information regarding the Medicaid participant you are requesting services for.

Medicaid Participant Information		
First Name:	Last Name:	
Medicaid ID:	Birthdate:	Phone:
I am requesting the service(s) listed below in excess of the standard Medicaid benefit limitations.		
Parent/Guardian/Participant Name:		Signature:
Email Address:		Date:

STEP #2 – I am the child's regular doctor OR the specialty physician who is referring the child for the service(s) and I have signed my approval below for the service(s) requested in Step #3.

Referring Physician Specialist or Primary Care Provider Information		
Provider Name:		Contact Person:
NPI/Provider #:	Fax:	Phone:

Please check the appropriate box (es) and affix your authorizing signature.

☐ I am the referring specialty physician (I will coordinate these services with the primary care provider.)

☐ I am the primary care provider.

☐ I examined the child named in Step #1 of this form or reviewed his/her medical record on _____.

➢ I affirm I am requesting the services listed in Step #3 of this form.

➢ I affirm my responses to the questions on this form support my determination the requested services are medically necessary to correct or ameliorate defects in physical and/or mental illness, and/or conditions discovered by the screening services.

Signature Date

STEP #3 – Tell us what type of service(s) you are requesting and provide the documentation listed for the service.

Service Identification

☐ **Outpatient Behavioral Health Service Requested: _____**

Submit both this application AND sufficient clinical documentation that substantiates the medical necessity of the request. To complete the review we need to receive member specific status and information, rather than general information. If Optum needs additional information to make a determination, we will contact you.

- Please describe the member's specific assessed needs that require the service being requested AND how the service will maintain, correct or improve the child's condition.
- Please document the name and a descriptive summary of the service(s) being requested and the necessary qualifications of the provider for these services.
- Related to the member, please describe the goals & objectives that will be addressed by the service being requested, along with the expected outcome of the service.
- What is the requested dates of service, frequency and duration of this service (note: services will not be backdated from approval date)?
- Describe the specific goals/objectives which CAN NOT be met without this service.
- Provide a list of the Behavioral Health Services the member is **currently** receiving, along with the names and credentials of these providers.
- Provide a list of other specialized Medicaid Services that this member receives such as DD Waiver Services, Personal Care Services, etc.
- If the member has received i**npatient or residential level care** for their Behavioral Health Needs in the last 6 months, please provide this information, and submit the information from the discharge report including discharge recommendations.
- Submit the most recent psychiatric assessment date & recommendations that has been completed within the last 6 months.
- Submit the most recent Comprehensive Diagnostic Assessment/Update for this member.
- Submit any other Treatment Records used to determine the member's need for the service you are requesting including: Progress Reports, Psychiatric Assessments and Psychological or NP Evaluations or other assessments.

If you need assistance obtaining any medically necessary service for a child up to the age of 21, please contact Optum Provider Line at (855) 202-0983 and press Option "1" to speak to the Clinical Department or by email at optumidaho_EPSDT@Optum.com.

STEP #4 – If you have identified a Medicaid provider that will deliver the additional service(s) you are requesting, please provide their information in the section below.

Medicaid Provider Information

Provider Name:		NPI/Provider #:
Date:	Phone:	Fax:
Email Address:		

STEP #5 – Submit this form and documentation for the service(s) to Optum Idaho by email to optumidaho_EPSDT@Optum.com or by fax at (855) 844-7042.