OPTUM® Idaho Behavioral Health Plan

Out-Of-Network Services Request Form

Requestor Information

Requestor Name: Requestor Phone Number:

Relationship to Member:

◯ Current Provider
Provider type:
Agency Address:

◯ Other Relationship:

Reason for Out-Of-Network Services Request: (Select One)

◯ Network Insufficiency ◯ Clinical Specialty ◯ Continuity of Care

Member Information

First Name: Middle Initial: Last Name:

Medicaid ID: Date of Birth: Age: Phone:

Parent/Guardian Name: Parent/Guardian Phone:

Member's Current Living Situation: (275 character limit)

Identified Out-of-Network Provider Information

Provider First Name: Provider Last Name:

Provider Credentials: Provider NPI#:

Provider E-Mail: Phone: Fax:

Agency Name: Tax ID#:

Address: Suite #:

City: State: Zip Code:

Are you interested in becoming an Optum Idaho Network Provider? ◯ YES ◯ NO

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Service Request Information

*Please indicate what service you are requesting, the associated CPT Code, Number of Units (**specify units, hours, or sessions**), and the Start Date and End Date of Service. If you need additional services, please attach the information on a separate page.*

Service Requested	CPT Code	Number of Units/Hours/Sessions	Service Start Date	Service End Date

Diagnosis and Reason for Request

Please indicate the PRIMARY diagnosis on the first line, then any additional diagnoses as appropriate. If there are more than 3 diagnoses, please attach the information on a separate page.

Diagnosis Code *ICD10 or DSM-V*	Diagnosis Description

Note: The text boxes below have a 625 character limit. If more space is needed please attach the information on a separate page.

Why are services being requested from an out-of network provider?

Please describe CURRENT Symptoms and Behaviors (include risk factors of suicidality/homicidality/violence or life stressors).

Why can't the requested services be obtained through an in-network provider?

Please describe the goals and objective that will be addressed by the service(s) being requested, along with the expected outcome of the service.

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Form Submission

Please submit to Optum Idaho both this completed service request form AND any current clinical documentation that supports the medical necessity of the request. Please select the documents attached to this request:

- ◯ Comprehensive Diagnostic Assessment (CDA)
- ◯ Psychological Evaluation
- ◯ Progress Notes
- ◯ Other. Describe below: **(225 character limit)**

Requestor Signature: **Date:**

Please submit via e-mail to optum_idaho_auths@optum.com, or by fax to (855) 708-9282. Thank you.