OPTUM® Idaho Behavioral Health Plan

Presumptive/Qualitative Drug Testing Service Request Form

Medicaid Participant Information

First Name: ____________ Middle Initial: ______ Last Name: ____________

Medicaid ID: ____________ Date of Birth: ____________ Age: 0 Phone: ____________

Parent/Guardian Name: ____________ Parent/Guardian Phone: ____________

Requesting Provider Information

Provider First Name: ____________ Provider Last Name: ____________

Provider Credentials: ____________ Provider E-mail: ____________

Provider NPI#: ____________ Phone: ____________ Fax: ____________

Agency Name: ____________ Tax ID#: ____________

Address: ____________ Suite#: ____________

City: ____________ State: ____________ Zip Code: ____________

Service Request Information

This provider recommends 12 units of Drug Testing for the remainder of the year: ○ YES ○ NO

If NO, how many units are you requesting for the remainder of the year? ____________

Service Start Date: ____________

Reason for Request

Select as many of the following statements that apply to member:

☐ The member is participating in Substance Use Disorder Treatment.

☐ The member is being assessed for possible Substance Use Disorder.

☐ The member has an altered mental status.

☐ The member has a possible overdose.

☐ The member has had multiple relapses in the past calendar year, requiring multiple treatment starts and episodes of frequent testing.

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Reason For Request (continued)

Why are additional units being requested? Note if member is in active treatment. Describe the evidence-based services that the member is engaged in.

Diagnosis Information

Does the member have a behavioral health diagnosis? ◯ YES ◯ NO

If YES, note the PRIMARY diagnosis first. Add additional rows for any additional diagnoses as needed.

Diagnosis Code *ICD10 or DSM-V*	Diagnosis Description	+Add
		Remove

If **NO**, is the member being assessed for a behavioral health diagnosis? ◯ YES ◯ NO

Form Submission

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

Provider Signature: ____________________ **Date:** __________