



Behavioral Health-Related Preauthorization—Initial Request

INSTRUCTIONS: Complete and submit the form below via email (see email addresses at the bottom of the page) with relevant clinical notes and medical necessity information. Once we receive this form, we have these decision days to make a benefit determination unless an expedited review is requested:

- **For Commercial Plans:** 14 days (Utah), 2 business days (Idaho), 10 days (Nevada), 5 business days (Colorado)
- **For Medicare:** 14 days (All States)

This request is (check one): **URGENT** **NON-URGENT**

IF you checked “URGENT” at left, please provide BOTH:

- Phone number of a person who can immediately discuss the case (not a general office number or answering service):

Immediate Contact Area Code/Ph #

- A medical provider's written explanation detailing how/why the usual decision days would:
 - Jeopardize the life or health of the member; and/or
 - Threaten the member's ability to regain maximum function; and/or
 - Subject the member to severe pain and inadequate management of the member's medical condition; and/or
 - Subject the member to severe pain that could not be adequately managed without the requested services.

Today's Date (mm/dd/year)

Dates of Service (mm/dd/year)

to

Contact Name

Email

Area Code/Ph #

Area Code/Fax#

PATIENT INFORMATION

Patient Name	Date of Birth (mm/dd/year)	Male	Female	City/State
Primary Insurer	ID#		Plan	
Secondary Insurer	ID#		Plan	

PROVIDER INFORMATION

Requesting Provider	NPI#	Area Code/Ph#
Complete Address		
Service Provider/Facility	NPI#	Area Code/Ph#
Complete Address		

REQUESTED SERVICES

Level of Care Requested*:

Describe below why this requested care level is appropriate for this patient:

Medicare members only: Intensive outpatient and partial hospitalization do not require preauthorization, and residential treatment is not covered.

CLINICAL INFORMATION

Previous Treatment	Facility	Type of Service	Type of Treatment		Dates of Service
			Psych	Substance Use	
			Psych	Substance Use	
			Psych	Substance Use	

Current Symptoms: Provide diagnostic codes for current behavioral health symptoms and/or medical complications from substance use.

How long have these symptoms/complications been present?

Does the patient have any current legal issues? Yes No If yes, describe

What is the patient's current job, school or caregiver status, and living arrangement?

Does the patient currently have support? Yes No If not, why?

Is the patient in a high-risk environment? Yes No If yes, explain

Any change in the clinical issues described above in the past 30 days? Yes No If yes, explain

DOCUMENTATION SUBMISSION

Submit completed form with relevant clinical notes and medical necessity information via email as follows:

- For Commercial Plans (Large Employer, Small Employer, Self-Funded, and Individual): commercialUMintake@imail.org
- For Select Health Community Care (Medicaid) or Children's Health Insurance Program (CHIP): medicaidUMintake@imail.org
- For Select Health Medicare: medicareUMintake@imail.org

Reduce turnaround time for preauthorizations by using CareAffiliate®. Some preauthorization requests even qualify for auto-approval. To learn more, email careaffiliate@selectthehealth.org.