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selecthealth

BEHAVIORAL HEALTH-RELATED PREAUTHORIZATION—INITIAL REQUEST

INSTRUCTIONS: Complete the form below, and submit via email (see email addresses at the bottom of the page) with relevant clinical notes and medical necessity information. Once SelectHealth® receives this form, we have **at least 10 days** to make a decision.

For an expedited review, provide the phone number of a person who can immediately discuss the case (not general office or answering service) **AND** include a letter or documentation from a medical provider explaining how/why the usual time frame would:

- Jeopardize the life, health, or ability to regain maximum function; and/or
- Threaten the member's ability to attain, maintain, or regain maximum function; and/or
- Subject the member to severe pain that could not be adequately managed without the requested services.

Today's Date ________/________/________ Dates of Service ________/________/________to ________/________/________

Contact Name ____________________ Email ____________________

Ph # (________)____________________ Fax# (________)____________________

Immediate Contact Ph # (required for expedited request) (________)____________________

PATIENT INFORMATION

Patient Name ____________________ Date of Birth _____/_____/_____ Male ❑ Female ❑ City/State ____________________

Primary Insurer ____________________ ID# ____________________ Plan ____________________

Secondary Insurer ____________________ ID# ____________________ Plan ____________________

PROVIDER INFORMATION

Requesting Provider ____________________ NPI#____________________ Ph#(________)____________________

Street Address ____________________ City/State ____________________

Service Provider ____________________ NPI#____________________ Ph#(________)____________________

Street Address ____________________ City/State ____________________

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

	Facility	Type of Service	Type of Treatment	Dates of Service
Previous Treatment			❑ 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 SelectHealth Community Care (Medicaid) or Children's Health Insurance Program (CHIP): **medicaidUMintake@imail.org**
- For SelectHealth Advantage (Medicare): **medicareUMintake@imail.org**

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