P.O. Box 30192
Salt Lake City, UT 84130
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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 **14 days** (in Utah), **2 business days** (in Idaho), and **10 days** (in Nevada) to make a benefit determination unless an expedited review is requested.

This request is (check one): ☐ **NON-URGENT** ☐ **URGENT*** **IF you checked "URGENT,"** provide the phone number of someone who can immediately discuss the case (not a 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 (mm/dd/year) Dates of Service (mm/dd/year) to

Contact Name Email

Area Code/Ph # Area Code/Fax#

Immediate Contact Area Code/Ph # (required for expedited request)

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

Requesting In-Network Benefits? **Yes** ☐ **No** ☐

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 Medicare™: medicareUMintake@imail.org

Ask us how to get access to the CareAffiliate tool — an electronic provider submission tool that can reduce turnaround time for preauthorization requests. It is quick and reliable, and some requests qualify for auto-approval. To learn more about this tool, email: careaffiliate@selecthealth.org.