# Select Health — 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 Select Health® receives this form, we have **14 days** (in Utah), **2 business days** (in Idaho for commercial products), **5 business days** (in Colorado), and **10 days** (in Nevada) to make a benefit determination unless an expedited review is requested.

**For an expedited review**, 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 days (see above) 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

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 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@selecthealth.org.