

INSTRUCTIONS: Complete and submit the form below with relevant clinical notes and medical necessity information via email to commercialUMintake@imail.org. Once we receive this form, we will make a benefit determination within 5 days unless an expedited review is requested.

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

***Scheduling issues DO NOT meet criteria for "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)

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?

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 to commercialUMintake@imail.org.