OPTUM® Idaho Behavioral Health Plan

Intensive Home and Community Based Services Request Form

Received Date:	Authorized:	PA Number:

Medicaid Participant Information

First Name: _____ Middle Initial: _____ Last Name: _____

Medicaid ID: _____ Date of Birth: _____ Age: 0 Phone: _____

Parent/Guardian Name: _____ Parent/Guardian Phone: _____

Member's Current Living Situation:

_____

Requesting Provider Information

Provider First Name: _____ Provider Last Name: _____

Provider Credentials: _____ Provider E-mail: _____

Provider NPI#: _____ Phone: _____ Fax: _____

Agency Name: _____ Tax ID#: _____

Address: _____ Suite#: _____

City: _____ State: _____ Zip Code: _____

Service Request Information

Intensive Home and Community Based Services (IHCBS) Treatment Modality: *(select one)*

- ☐ Functional Family Therapy (FFT)
- ☐ Multi Dimensional Family Therapy (MDFT)
- ☐ Multi Systemic Therapy (MST)

Note:
Providers that have identified an IHCBS evidence-based practice that is not FFT, MDFT or MST should utilize the Early Periodic Screening Diagnosis and Treatment (EPSDT) process to request the service for the member. For additional information about EPSDT or complete an EPSDT form, providers should refer to *www.OptumIdaho.com* > *For Network Providers* > *Forms* and/or information in the Provider Manual on EPSDT.

Is this an **INITIAL** IHCBS treatment request for this member? ☐ Yes ☐ No

Number of Units Requested: _____

Service Start Date: _____ Service End Date: _____

Continued on Page 2

Diagnosis/Reason for Request

Diagnosis Information

Please indicate the PRIMARY diagnosis first then add additional rows for any additional diagnoses as appropriate.

Diagnosis Code *ICD10 or DSM-V*	Diagnosis Description	+Add
		Remove

Why does the member need Intensive Home and Community Based Services (IHCBS) at this time?

Please describe CURRENT Symptoms and Behaviors (include risk factors of suicidality/homicidality/violence or life stressors)

Does the member have any available natural supports and resources? ***(If yes, please describe)***

Does the member have any history of trauma? ***(If yes, please describe)***

Please describe the goals and objectives that will be addressed by the service being requested, along with the expected outcome of the service.

Provider Attestation

Attestation confirms that the requesting provider is credentialed.

< Please enter Provider First Name, Last Name, and Credentials in the Requesting Provider Information section above >

- ☐ Functional Family Therapy (FFT) site certification from FFT, LLC and follow the guidelines as set by FFT, LLC.
- ☐ Multi Dimensional Family Therapy (MDFT) certification from MDFT International and follow the guidelines as set by MDFT International.
- ☐ Multi Systemic Therapy (MST) certification from the MST Institute and follow the guidelines as set by the MST Institute.

Provider Signature: _____ **Date:** _____

Please submit to Optum Idaho both this completed service request form AND any clinical documentation that supports the medical necessity of the request. Examples of clinical documentation may include, but is not limited to: most recent Comprehensive Diagnostic Assessment (CDA), Progress Reports, Psychological Evaluations or other assessments, and/or other related treatment records.

Please submit via e-mail to optum.idaho.ihcbs_dt@optum.com, or by fax to (844) 441-9777. Thank you.