IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LISA HETTINGER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

PRIOR AUTHORIZATION

Requests for Additional Services – Early Periodic Screening, Diagnosis and Treatment

If a child (up to the age of 21), needs medically necessary services that exceed the limitations of the Medicaid State Plan, additional services through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit can be approved. EPSDT prior authorization requests may be submitted by a child's primary care provider (PCP) who determines the child needs additional treatment for a primary health condition. In this instance, the PCP orders the services for the child. If the services can't be provided by the PCP, the PCP will make an appropriate referral.

Children receiving benefits through the Idaho Behavioral Health Plan (IBHP) may request additional community-based outpatient behavioral health services that are medically necessary directly from Optum Idaho. The managed care contractor can be contacted by calling **1-855-202-0973.**

A Request for Additional Services (prior authorization) must be completed by the parents/guardians (or the participant) and providers before Medicaid can review or approve payment for the treatment/service as outlined below:

- Request for Additional Services EPSDT form – **The parent/guardian must consent by completing and signing this form. The service provider and primary care provider MUST complete and sign their sections of the form.**
- Required documentation (by type of service requested) as listed below must be submitted with this request.

After all of the required documents are received, staff who serve as experts for the types of services requested, will review the information. In about two weeks, the parents/guardians (or the participant) will receive a Notice of Decision from the Department telling them whether the request for service(s) was approved or denied. If the request is denied, parents/guardians may appeal the decision as indicated on the Notice of Decision.

<table>
<tr><th colspan="2">REQUIRED DOCUMENTATION</th></tr>
<tr><td colspan="2">Behavioral Health Services: Optum Idaho directly processes EPSDT requests for outpatient behavioral health services. Contact Optum at 1-855-202-0973 or access the form at: EPSDT Request Form</td></tr>
<tr><td>Developmental Disabilities Services:
☐ Graphed Data (last 3 months), if application is for a renewal of an EPSDT service
☐ Please include a brief descriptive summary of the service being requested and the provider qualifications.
☐ Any relevant documentation that demonstrates that the requested service will help correct or ameliorate the child's condition and that it is safe, effective and meets acceptable standards of medical practice.</td><td>Individualized Educational Plan (IEP) identified Services
☐ Current IEP
☐ 120 day progress review
☐ Eligibility determination documentation
☐ Service Detail Reports (last 3 months if applicable)
☐ Any relevant documentation that demonstrates that the requested service will help correct or ameliorate the child's condition and that it is safe, effective and meets acceptable standards of medical practice.</td></tr>
<tr><td>Personal Care Services
☐ Complete list of the name and amount of services currently being received
☐ Plan of Care
☐ Current History & Physical (H&P)</td><td>Other Services:
☐ Complete list of the name and amount of services currently being received.
☐ Any relevant documentation that demonstrates that the requested service will help correct or ameliorate the child's condition and that it is safe, effective and meets acceptable standards of medical practice.</td></tr>
</table>

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
Return by Email: ***EPSDTRequest@dhw.idaho.gov, or***
Fax: ***208-364-1811, Attn: EPSDT Request, or***
Mail: ***EPSDT Request, IDHW – Division of Medicaid, P.O. Box 83720, Boise, ID 83720-0036***

Idaho Medicaid Request for Additional Services

Please complete entire form and submit all required documentation listed in instructions.

Medicaid Participant Information		
First Name:	Last Name:	
Medicaid ID:	Birthdate:	Phone:
I am requesting the services listed below in excess of the standard Medicaid benefit limitations.		
Parent/Guardian/Participant Name:	Signature:	

Medicaid Provider Information		
Provider Name:		NPI/Provider #:
Date:	Phone:	Fax:
I hereby declare that the above named child needs additional services. The additional services will be provided according to the current treatment plan. The services will not be provided for cosmetic purposes or for the convenience or comfort of the child, parent/guardian, or provider.		Signature:

Primary Care Provider Information		
Provider Name:		NPI/Provider #:
Contact Person:	Phone:	Fax:
I am the primary care provider for the above named child. I examined this child or reviewed his/her medical record on:_____. I agree that the additional services being requested are necessary to correct or ameliorate defects of physical or mental illness. There is no other equally effective course of treatment available or suitable for the child.		Signature:

Please Identify Requested Services:	
Developmental Disabilities Services:	**IEP Services:**
Personal Care Services:	**Other Services:**

Additional Information

Why does your child need the requested additional service(s)?

How will the requested service(s) maintain, correct or improve your child's condition?

What specific goals will be achieved with this additional service/product?

What amount of service is being requested (i.e. 2 additional hrs. per week for 12 weeks)?

Describe what specific goals/objectives can't be met without additional services:

(Department Use Only) Please do not write in area below		
Received Date:	Authorized: Y N	PA Number:

Clear Form