Reset Form

Prior Authorization Form
Early Intensive Developmental & Behavioral Intervention (EIDBI)

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form and allow 14 calendar days for decision.

For questions, call Mental Health and Substance Use Disorder Services at:
612-676-6533 or **1-833-276-1185**

To **fax** form and any relevant documentation:

For **initial** admission notifications:
612-884-2033 or **1-855-260-9710**

Submit Request: UCare's Secure Email Site
Intake: MHSUDservices@ucare.org

MEMBER INFORMATION

UCare ID _____ PMI _____

Member Name _____ DOB _____

Address _____

City, State, Zip _____ Phone _____

SERVICING CLINIC INFORMATION

Clinic Name _____ NPI Number _____

Service Location Address _____

City, State, Zip _____

Contact Phone _____ Fax _____

REQUESTER INFORMATION

Request Sent By _____ Email _____

Phone _____ Total Pages Faxed _____

○ STANDARD REVIEW	○ EXPEDITED REQUEST
Standard review timeframe for an authorization decision is within 14 calendar days or 10 business days from the date the request was received, as expeditiously as the member's health condition requires.	Only request an urgent/ emergent review if waiting the standard review timeframe would potentially jeopardize the member's health, life, or ability to regain function. Expedited decision within 72 hours. Billing and retrospective authorizations are not expedited.

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INITIAL START OF SERVICES/PROCEDURE CODES/UNITS

INITIAL START OF SERVICES	Start Date	End Date

Please list all necessary code(s) and units associated with your visit.

ICD-10: _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Attach applicable documentation:

☐ Individual Treatment Plan ☐ Comprehensive multi-disciplinary evaluation (CMDE), if available

CONTINUATION OF SERVICES/PROCEDURE CODES/UNITS

CONTINUATION OF SERVICES	Start Date	End Date

Please list all necessary code(s) and units associated with your visit.

ICD-10: _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Attach the following documents if applicable:

☐ Individual Treatment Plan ☐ Progress Notes (from past 60 days)

Additional information that may support medical necessity: