INDEPENDENT CARE HEALTH PLAN
*i*Care is a wholly-owned subsidiary of Humana

Behavioral Health Prior Authorization Request Form

Please fill out this form completely and fax to 414-231-1026
For PA Status call Customer Service at 414-223-4847
*i*Care Prior Authorization Department 414-299-5539 or 855-839-1032

Member Information			
Line of Business:	*i*Care FamilyCare Partnership □ Dual □ Medicare □ Medicaid	□ *i*Care Medicaid SSI	□ *i*Care BadgerCare Plus
Member Name:		DOB:	
Member ID #:		Phone:	
Service Type:	□ Court Ordered Service (72-hr. turnaround time)	□ Clinical Trial (72-hr. turnaround time)	
	□ Elective/Routine (7-day turnaround time)	□ Expedited/Urgent/ (72-hr. turnaround time)	
	□ Outpatient Services	□ Inpatient Services	

Definition of Urgent/Expedited: when the treatment requested is required to prevent imminent, serious deterioration in the member's health or threaten to jeopardize the member's ability to regain maximum function.
***i*Care reserves the right to deny the request for urgent review for all requests outside of this definition.**

Servicing Provider Information (facility/ supplier who will perform service/procedure)		
Provider/Supplier Name:		NPI:
UR Contact Name:	Tax ID Number:	Phone:
Address:		
Email:		Fax:

Ordering/Admitting Practitioner Information (practitioner who ordered service/procedure)		
Practitioner Name:		NPI:
UR Contact Name:	Tax ID Number:	Phone:
Address:		
Email:		Fax:

Referral/ Service Request			
Inpatient Admission:	□ Mental Health □ Substance Use	**Outpatient Admission:**	□ Mental Health □ Substance Use
□ Initial Request □ Concurrent Request □ Retrospective □ Transfer from another facility □ Voluntary □ Emergency/Involuntary □ Forensic Admission **If Involuntary, Court Date: _____** **Admit Date: _____ Time: _____**		□ Partial Hospital Program (PHP) □ Intensive Outpatient Program (IOP) □ **H2012** _____ units in hour increments for _____ days per week □ **H2019** _____ units in 15 min increments for _____ days per week **Start Date: _____ End Date: _____**	

INDEPENDENT CARE HEALTH PLAN (*i*Care)
1555 N RiverCenter Dr. Suite 206, Milwaukee, WI 53212
www.iCareHealthPlan.org

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□ **Continuity/ Transition of Care request**	*Please check if this request is for an active course of treatment previously approved by another insurance carrier/Medicare HMO*

Date	Name – Provider	Primary Diagnosis Code	Primary Diagnosis Description
Psychosocial Barriers:			

Previous Treatment (Complete this section for all initial PA requests. For subsequent PA requests, provide updates as needed.)

Has the member recently completed any types of treatment not previously documented on the prior PA?
□ **Yes** Please provide updated details (Do not repeat previously reported information)
□ **No** Skip and go to the next section

A	Type of Treatment:	Start Date (MM/YY):	End Date (MM/YY):
Name of Agency, City / State:		Name – Person Who Supervised Treatment:	
Results / Effectiveness:			
Reason for Discontinuing:			
B	Type of Treatment:	Start Date (MM/YY):	End Date (MM/YY):
Name of Agency, City / State:		Name – Person Who Supervised Treatment:	
Results / Effectiveness:			
Reason for Discontinuing:			
C	Type of Treatment:	Start Date (MM/YY):	End Date (MM/YY):
Name of Agency, City / State:		Name – Person Who Supervised Treatment:	
Results / Effectiveness:			
Reason for Discontinuing:			
D	Type of Treatment:	Start Date (MM/YY):	End Date (MM/YY):

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Name of Agency, City / State:	Name – Person Who Supervised Treatment:
Results / Effectiveness:	
Reason for Discontinuing:	

Age-Normed Testing
Document the most recent age-normed testing completed by the provider or other entities (such as a diagnostician or school).

Assessment Type	Test Date	Clinician	Tool	Results / Score
IQ				
Cognition (Other)				
Communication				
Adaptive Behavior				
Other				
Other				

Skill Assessment

Attach a current POC that addresses all of the following:

- Start date of treatment with the agency
- Treatment approach or protocol to be used
- Details of any medical conditions that may impact delivery of treatment or the member's response to treatment, such as visual or hearing impairment, or mental health concerns.
- Specific, objective, functional goals for the member, to be met by the end of the authorization period, with measurable criteria for assessing progress and mastery.
- Behavior reduction and functional replacement goals for each behavior targeted for reduction
- Plan for family involvement, including frequency and modes
- Specific, measurable goals (if family treatment guidance is requested)
- Details about interpretation services or other accommodations for communication barriers when needed
- Discharge criteria and transition plan

Progress Summary (Complete this section for all subsequent PA requests and for initial requests for members who are already receiving treatment.)

Attach a summary of recent progress that addresses all of the following:

- A description of the member's response to treatment during the most recent authorization, including signs of overall improved functioning.
- The introductory date and progress or mastery date for each targeted goal
- Measurable baselines and progress measures toward member and family goals, using consistent units of measurement that compare functioning at the beginning and end of the authorization period
- In the case of limited progress, identification of barriers to progress or corrective actions that have been attempted, including Functional Behavior Assessment (FBA), Functional Assessment (FA), or consultation with other specialties.
- In cases of limited progress, a corrective action plan to address the identified barriers, with a rationale for ongoing treatment at the level of service requested.

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Required supporting documentation. All documents must include the member's name and ID on the first page.
Required Supporting Documentation (Check box if included with submission.) **Note:** Additional information may be requested with any PA request to establish the medical necessity of the service
□ PA Request Form (initial and consecutive/ concurrent)
□ Diagnostic Report
□ Current Provider's Assessment
□ Age-Normed Test Results
□ Current POC
□ Schedule of Treatment, School, and Services
□ Progress Summary
□ Individualized Education Program
I attest to the accuracy of the information on this PA request. I understand that I am responsible for the supervision of the other team member(s) identified on this form. I, or someone with comparable qualifications, will always be available to the other team member(s) when they are in the home alone working with the child/family.
Signature – Licensed Professional/ Credentials:

Clinical notes, supporting documentation, and physician orders are required to determine medical necessity.

Receipt of an approved prior authorization does not guarantee coverage or payment by iCare Benefits are determined based on the dates that the services are rendered. An incomplete form may delay processing and/or claim payment.