Psychiatric Medical Institutions for Children (PMIC) Treatment Authorization Form

AmeriHealth Caritas Iowa

This form is completed by a PMIC provider and/or a referring agency. The purpose of this form is to request authorization for PMIC services, and this form is sent only to the Behavioral Health Utilization Management (BH UM) department to initiate a request by fax at **1-844-214-2469**. If you have any questions, please contact BH UM at **1-844-214-2474**.

Important note: BH UM will contact the provider or referral source to schedule a telephonic review to determine medical necessity for the requested service.

Referral information	
Referring facility or agency:	
Referral contact:	Date of referral:
Phone number:	Fax number:

Demographic information			
Child's name:		Date of birth:	Age:
Medicaid ID number:		AmeriHealth Caritas Iowa ID number:	
Ethnicity:		Primary language:	
Address:		City:	
State:	ZIP code:	Phone number:	
Integrated Health Home (IHH) involvement?: ☐ Yes ☐ No			
IHH name:		IHH phone number:	
Custody (e.g., Iowa Department of Human Services [DHS], parents, other family, other agency):			
Custodian name:			
Relationship:		Phone number:	

PMIC information	
Provider name:	Phone number:
Contact person:	Phone number:
National Provider Identifier (NPI):	
Tax ID number:	Fax number:

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Treatment request
When was the PMIC placement first requested or recommended for this member?
Who requested or recommended it?
When is the member scheduled to be admitted to a PMIC? Date:
What is the member's current status or placement?

Supporting documentation required with each request for services:

- Court order for placement (if applicable).
- Most recent psychiatric and/or psychosocial evaluation.
- Independent assessment (required to be completed within 45 days before admission).
- Most recent individualized education plan (IEP).
- Certificate of Need will be required prior to admission.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review, or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Signature of referring person/PMIC:_____ Date:_____

Referring person/PMIC's title: _____

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