BH Authorization Request Form

* denotes a required field

Member/Provider Identification

*IEHP ID:	IEHPID
*Are you submitting a correction to an existing authorization?	Yes / No
*Requesting Provider:	

Member Information

Name:	Gender:	DOB:	Age:
Address:	City:	State-Zip:	Phone:
IEHP ID:	CIN:	MediCare:	Medi-Cal:
LOB:	County:	Aid Code:	Group:

Requesting Provider Information

Name:	ID:	NPI #:	Phone:
Address:	City:	State-Zip:	Fax #:
Request Date:	Provider Signature:		

Referral Information

IEHP strongly encourages communication between treating specialists and referring Providers, to support coordination and integration of care efforts for our Members. Therefore, we request that a Release of Information be signed by our Member and included with this form, which will allow the information contained on this form to be shared securely with the designated provider through IEHP's Provider Portal.

Last Known Member Phone # (e.g. 9991234567):	
*Verified Member signed the required Release of Information Form allowing IEHP to release medical and behavioral health information to PCP or Referring Provider.	Yes / No

Please attach completed Release of Information form in the Supporting Documents section below. Click here to print the release.

*Discussed referral with Member who is in agreement.	☐

Service Information

*Service Requested:	BH Medication Consult & Treatment
*Has the Member been on medication before?	Yes / No
*Is the Member currently on medication?	Yes / No
*Please Specify	
*Is the Member currently in psychotherapy (talk therapy)?	Yes / No
*Servicing Provider: (Must refer to specialist within network)	Any-In-Network

Service Priority

*Is the Authorization a patient request?	Yes / No
*Service Priority (Medi-Cal: Decision within 5 Business Days) (CMC: Decision within 14 Calendar Days)	Expedited / Standard Pre-Service / Standard Post-Service Appt Date: MM/DD/YYYY

FOR DRAFT USE: MUST SUBMIT VIA IEHP WEB PORTAL

ICD Codes

Select Service Priority and/or Appt Date before entering ICD codes. ICD codes will be cleared if the Priority or Appt Date is modified. If Diagnosis is unknown, please submit V Code.

*ICD 1:

Add +

CPT Codes

*CPT 1:	Modifier:	*Qty:(numeric only)

Add +

Special Instructions/Comments

Special Instructions / Comments

Attach Supporting Documents

Up to 8 PDF or Word files, 10 MB per file maximum size

Note: Dragging and dropping files into browser window may navigate away from page

Filename	Size	Status
Add Files	0 b	0%

Submit Cancel

FOR DRAFT USE: MUST SUBMIT VIA IEHP WEB PORTAL