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DIVISION OF MEDICAID
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**PRIOR AUTHORIZATION
For Services under
Early Periodic Screening, Diagnostic and Treatment**

If a child (through the month of their 21st birthday), needs medically necessary services that are not covered under the Idaho Medicaid State Plan, (see IDAPA 16.03.09.880) then additional services may be approved through the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

Requests for EPSDT services must be prior authorized. The prior authorization request must be submitted by either the child's primary care provider (PCP) or a specialty physician who determines that the child needs additional treatment for a physical or mental health condition. If the services can't be provided by the PCP, the PCP will make an appropriate referral by completing the appropriate information on this request. Specialty physicians making this referral for EPSDT services must coordinate services with the child's PCP. The request must include:

- **The PCP/specialty physician recommendation for the service**
- **The parent/guardian's consent**
- **All appropriate provider sections must be completed and signed.**
- **Required documentation for the type of service requested (as listed in STEP #3) must be submitted.**

Department staff will review the submitted documentation and render a decision. In about two weeks, the parents/guardians will receive a Notice of Decision from the Department informing them whether the request for EPSDT services was approved or denied. If the request is denied, the parents/guardians may appeal the decision as indicated on the Notice of Decision.

Please complete all information on pages 2 and 3 of this packet and submit all required documentation listed for the type of service you are requesting. If the Department staff reviewer needs additional information, they will contact you.

Requests must be submitted by email, fax, or mail to:

**Idaho Medicaid Request for Additional Services
Early Periodic Screening, Diagnostic, and Treatment (EPSDT)**

Email: EPSDTRequest@dhw.idaho.gov

Fax: 208-364-1811, Attn: EPSDT Request

Mail: EPSDT Request, IDHW – Division of Medicaid,
P.O. Box 83720, Boise, ID 83720-0036

If you have questions about EPSDT or about completing this packet, please contact our EPSDT Coordinator at (208) 364-1983 or by email to EPSDTRequest@dhw.idaho.gov.

EPSDT PRIOR AUTHORIZATION REQUEST FORM

Received Date:	Authorized: Y N	PA Number:
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STEP #1 – Provide information regarding the Medicaid participant you are requesting services for.

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:	
Email Address:		Date:	

STEP #2 – I am the child’s regular doctor OR the specialty physician who is referring the child for the service(s) and I have signed my approval below for the service(s) requested in Step #3.

Referring Physician Specialist or Primary Care Provider Information

Provider Name:		Contact Person:	
NPI/Provider #:	Fax:	Phone:	

Please check the appropriate box(es) and affix your authorizing signature.

- I am the referring specialty physician (I will coordinate these services with the primary care provider.)
- I am the primary care provider.
- I examined the child named in Step #1 of this form or reviewed his/her medical record on: _____.
- I affirm I am requesting the services listed in Step #3 of this form.
- I affirm my responses to the questions in Step #4 of this form support my determination the requested services are medically necessary to correct or ameliorate defects in physical and/or mental illness, and/or conditions discovered by the screening services.

Signature _____ Date _____

STEP #3 – Tell us what type of service(s) you are requesting and provide the documentation listed for the service. *(See Section IV.i “Review Time” of the Idaho Medicaid EPSDT Policy for approximate review times.)

Service Identification

<p><input type="checkbox"/> Developmental Disabilities Services</p> <p>Submit the following documentation:</p> <ul style="list-style-type: none"> • A brief descriptive summary of the service(s) being requested and the necessary qualifications of the provider. • Describe the goals, objectives, and outcomes you expect to achieve and amount of time per week necessary to implement them. • For renewals of EPSDT services: Graphed Data for previously authorized (3 months) of EPSDT service(s). 	<p><input type="checkbox"/> Educational Setting Services</p> <p>Submit the following documentation for initial requests:</p> <ul style="list-style-type: none"> • Current Individualized Education Plan, 504 Plan, or private school learning plan • 120 day progress review. • Service eligibility determination documentation. <p>For renewals of EPSDT services:</p> <ul style="list-style-type: none"> • Service Detail Reports (last 3 months, if applicable)
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<input type="checkbox"/> Residential Behavioral Health Services Submit the following documentation: <ul style="list-style-type: none"> • Treatment Records. • Comprehensive Diagnostic Assessment. • Psychological/Neuropsychological Assessment. Progress/case notes demonstrating behaviors and all behavioral health services received for previous six months.	<input type="checkbox"/> Medications or Out of State Facilities Submit the following documentation: <ul style="list-style-type: none"> • CPT code. • Signed Physicians Order. Pharmacy Name: _____ Phone#: _____
If you need assistance obtaining any medically necessary service for a child up to the age of 21, please contact our EPSDT Coordinator at (208) 364-1983 or by email to EPSDTRequest@dhw.idaho.gov.	

STEP #4 – Tell us about the child’s needs for this service. (To be completed by the PCP or referring specialist)

Additional Information
<p>Why does the child need the requested additional service(s)?</p> <p>How will the requested service(s) maintain, correct or improve the child’s condition?</p> <p>What specific goals will be achieved with this additional service/product?</p> <p>What amount of service is being requested and for how long? (e.g., 2 additional hrs. per week for 12 weeks).</p> <p>Describe specific goals/objectives which can’t be met without the service(s):</p>

STEP #5 – If you have identified a Medicaid provider that will deliver the additional service(s) you are requesting, have them complete the section below.

Medicaid Provider Information			
Provider Name:		NPI/Provider #:	
Date:	Phone:	Fax:	
Email Address:			

STEP #6 – Submit this form and documentation for the service(s) to Idaho Medicaid at:

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