



**Iowa Medicaid Enterprise (IME)  
Inpatient Psychiatric Prior Authorization**

**I. Referral Information**

Review Type	<input type="checkbox"/> Admission	<input type="checkbox"/> Continued Stay
Hospital Facility Name		NPI
Contact Person		Telephone
Date of Admission		Court Ordered <input type="checkbox"/> Yes <input type="checkbox"/> No
		Hearing Date

**II. Member Information**

Member Full Name			
Medicaid ID Number		Date of Birth	
Presumptive/Month of Application		Date of Last Authorization	
Living Arrangement	<input type="checkbox"/> Alone <input type="checkbox"/> Parent/Guardian	<input type="checkbox"/> Shelter <input type="checkbox"/> Other	<input type="checkbox"/> Spouse/Partner

**III. Diagnosis (*List all current diagnoses*)**


**IV. Current Medications (*List all current psychotropic medications*)**

Drug Name	Dosage	Frequency

**V. Symptoms and Precipitating Events (Provide details regarding the precipitating events and symptoms/behaviors to support recommendation for inpatient hospitalization)**

**Check all that apply and provide details:**

- |  |  |   |                                    |
|--|--|---|------------------------------------|
| <input type="checkbox"/> Auditory hallucinations | <input type="checkbox"/> Paranoia        | <input type="checkbox"/> Mood/affect        | <input type="checkbox"/> Speech    |
| <input type="checkbox"/> Visual hallucinations   | <input type="checkbox"/> Thought content | <input type="checkbox"/> Dementia/cognition | <input type="checkbox"/> Delusions |
| <input type="checkbox"/> Insight/judgment        | <input type="checkbox"/> Anxiety level   | <input type="checkbox"/> Sleep/hygiene      | <input type="checkbox"/> Behavior  |

Details:

**Imminent risk to self (Check all that apply and provide details):**

- Recent suicide attempt or serious self-harm
- Current plan for suicide or serious self-harm
- Command auditory hallucinations for suicide or serious self-harm

Details:

**Imminent harm to others (Check all that apply and provide details):**

- Recent action
- Current plan
- Command auditory hallucinations for homicide or serious harm to others

Details:

**VI. Substance Abuse History**Provide toxicology screen results (*Check all that applies*):

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Alcohol - BAL | <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Cannabis      | <input type="checkbox"/> Inhalants       | <input type="checkbox"/> Narcotics    |
| <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Amphetamines    | <input type="checkbox"/> OTC Meds     |

Details:

CD Consult Recommendation

Discharge Plan

I confirm all information is a true and accurate description of the above individual.

Completed by  
(Print Name)

Email

Date

Upon completion of the form, please click the **"SUBMIT"** button below which sends the completed prior authorization form to the IME Medical Services Unit.

**For IME Use Only:****SUBMIT**