Iowa Department of Human Services

Iowa Medicaid Enterprise (IME)
Inpatient Psychiatric Prior Authorization

I. Referral Information

Review Type	☐ Admission	☐ Continued Stay		
Hospital Facility Name		NPI		
Contact Person		Telephone		
Date of Admission		Court Ordered ☐ Yes ☐ 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	☐ Alone ☐ Parent/Guardian	☐ Shelter ☐ Other	☐ 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:

- ☐ Auditory hallucinations
- ☐ Paranoia
- ☐ Mood/affect
- ☐ Speech
- ☐ Visual hallucinations
- ☐ Thought content
- ☐ Dementia/cognition
- ☐ Delusions
- ☐ Insight/judgment
- ☐ Anxiety level
- ☐ Sleep/hygiene
- ☐ 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*):

- ☐ Alcohol - BAL
- ☐ Benzodiazepines
- ☐ Barbiturates
- ☐ Cannabis
- ☐ Inhalants
- ☐ Narcotics
- ☐ Hallucinogens
- ☐ Amphetamines
- ☐ 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