IDAHO MEDICAID
HEALING ARTS THERAPY
PRIOR AUTHORIZATION REQUEST

To Requesting Provider:
Please complete form, attach required documentation and fax to 208.332.7280

PLEASE FILL IN ALL BOXES - **ALL** INFORMATION IS REQUIRED

Today's Date:
Participant:
Medicaid ID #
DOB:
Phone:
Requesting Provider:
Address:
City/Zip:
Phone:
FAX:
Provider Medicaid ID #
Healthy Connections Referral #
Prior authorization requested for visits beginning (date): and ending:
Number of visits requested between these dates:
Brief Therapy Description, ICD -9, and CPT Codes:

The following supporting documents should demonstrate medical necessity for therapy service, and must be attached in order to receive prior authorization:

Current signed and dated physician order

Current Therapy Evaluation

Current Plan of Care

Current Progress Report

Copies of therapy notes for all treatment within the last 30 days

Copies of IEP/IFSP therapy plans, if applicable

Once all documentation is received we will respond within 24 hours.

Mail or Fax to: Division of Medicaid, Medical Care Unit
Therapy Reviews
PO Box 83720
Boise, Idaho 83720-0036

Phone: 208-364-1830

Fax: 208-332-7280