

**ACT INITIAL AUTHORIZATION REQUEST FORM  
(ACT – IA)**

<b>To be Completed by OBH</b>				<i>Revised 2.16.16</i>
<b>Tracking #</b>		<b>Date/Time of Receipt</b>		
<b>PROVIDER INFORMATION</b>				
<b>Provider Company Name</b>				
<b>Person Making Referral</b>		<b>Credentials</b>		
<b>Provider Phone #</b>		<b>Provider Fax #</b>		
<b>Date of Request</b>		<b>Provider Email</b>		
<b>Provider Address</b>				
<b>CLIENT INFORMATION</b>				
<b>Recipient Name</b>				<b>SS#</b>
<b>Age</b>		<b>DOB</b>		<b>Ethnicity</b>
<b>Gender</b>		<b>Gender Expression</b>		<b>Marital Status</b>
<b>Parent/Guardian</b>		<b>Phone #</b>		
<b>Address</b>				
<b>ACT INITIAL AUTHORIZATION REQUEST</b>				
<b>Admit Date</b>		<b>Requested Length of Stay</b>		
<b>Requested Start Date</b>		<b>Requested End Date</b>		
<b>Last Date Authorized by Magellan (if applicable)</b>				
<b>Presenting Problem</b>				
<b>Diagnosis</b>				
<b>ICD10 Code</b>				
<b>Current Medications</b>				
<b>Substances Using/Treatment</b>				
<b>Recent UDS, BAL</b>				
<b>Medical Problems (current/recent diagnosis)</b>				
<b>Supports</b>				
Please outline the patient's current and past psychiatric and substance use history (including current diagnoses and symptoms, hospitalizations/ER visits, history and/or presence of suicidal/homicidal ideation, interactions with law enforcement due to mental illness/substance use, etc.).				
<b>Comment</b>				
<b>What circumstances, assessment results, or referrals indicate the need for ACT at this time (i.e., judicial or probation/parole recommendations, inability to meet basic needs, etc.)?</b>				
<b>Comment</b>				