Behavioral Health Individual Placement and Support Request Form

Submit completed form electronically using our preferred method at **Availity** or by fax to **1-833-974-0059**.

Today's date:	
Contact at provider's office:	Secure fax:
Name of requestor:	Phone:
Please note: Provide appropriate contact information, including best working phone number, for Humana staff to contact you if clarification or additional information is needed to complete the request.	

Member information		
Last name:	First name:	
Humana ID:	Medicaid ID:	Date of birth:
Parent/guardian name:		Phone:
Member's living arrangements: ☐ At home with guardian ☐ Group home ☐ Foster home		
Authorization reference number (if applicable):		

Requesting provider/facility		
Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Treating/servicing provider		
Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

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Diagnosis code(s) and date(s) of service (DOS)			
ICD-10*:	ICD-10*:	ICD-10*:	ICD-10*:
Admit date: ☐ Voluntary ☐ Involuntary, date of commitment:			
Start date of service:		End date of service:	
Type of request: ☐ Initial request ☐ Concurrent request			

* International Classification of Diseases, Tenth Edition.

Service code(s)		
Code:	Units:	Frequency:
Code:	Units:	Frequency:
Code:	Units:	Frequency:
Code:	Units:	Frequency:

Is member a part of the My Choice Louisiana program?

☐ Yes ☐ No

Is member receiving any other waiver services?

☐ Yes ☐ No

If yes, please list the waiver:

Reasons supporting the need for Individual Placement and Support (IPS):

Summarize the member's condition and provide clinically appropriate documentation:

Provider signature:	**Date:**