**Behavioral Health Inpatient/Outpatient Authorization Form (Non-Portal Users)**

DIRECTIONS: Please check the type of notice. All fields in **BOLD** are required to complete request.

Please Fax to 1-401-459-2503

|  |  |
| --- | --- |
| **Member Name:** | **Member DOB:** |
| **Member ID:** | **Authorization #** |
| **Facility /Provider Name:** | **Facility NPI:** |
| **Facility Address:** | **UM Contact Name:** |
| **Facility City and State: of s** | **UM Contact Phone Number:** |
| **Facility Main phone #:** | **UM Contact Fax Number:** |
| **Notes:** |  |

**Level of Care: Inpatient Services**  **Level of Care: Outpatient Services**

☐ Inpatient Substance Use/ Inpatient Withdrawal Management ☐ Transcranial Magnetic Stimulation-TMS

☐ Medical Board ☐ Partial Hospital Substance Use

☐ Residential Treatment Substance Use ☐ Partial Hospital Mental Health

☐ Residential Treatment Mental Health ☐ Intensive Outpatient Substance Use

☐ Crisis Stabilization Unit Mental Health ☐ Intensive Outpatient Mental Health

☐ Crisis Stabilization Unit Substance Use ☐ ABA

☐ Inpatient Mental Health ☐ Mental Health Child and Family Intensive Treatment CFIT /AIS

**Notice of Admission Initial Request**

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| --- | --- |
| **Admission Date:** | **Anticipated Discharge Date:** |
| **Procedure/CPT if applicable:** | **Number of Units requested:** |
| **Diagnosis Code:** |  |
| **Admitting Clinical Summary** | |

**Notice of Concurrent Request**

|  |  |
| --- | --- |
| **New Anticipated Discharge Date or request through Date:** | **Number of Additional Units:** |
| **Procedure/CPT if applicable/additional codes:** |  |
| **Notes:** | |

**Notice of Discharge** (Required for both Inpatient & Outpatient Requests)

|  |  |
| --- | --- |
| **Actual Discharge Date:** | **Number of units used:** |
| **Discharge Diagnosis Code:** | **Discharge Disposition: (REQUIRED)** |
| **Discharge Clinical Summary**  **Current Behavioral Health Providers:**  **Discharge plan with after care appointment details:**  **Medications:**  **Other:** | |