**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:**

**Facility /Provider Name: UM Contact Name and Phone Number:**

**Facility Address: Is facility in network with local BCBS  Yes  No**

**Notice of Admission Initial Request  Medical Necessity Initial Request** **(*FEP and providers not participating with local BCBS)***

*BCBSRI Reviewer will call to complete review telephonically*

**Level of Care:**

Medical Board  Inpatient Substance Use

Inpatient Mental Health  Inpatient Withdrawal Management

Crisis Stabilization Unit Mental Health  Crisis Stabilization Unit Substance Use

Residential Treatment Mental Health  Residential Treatment Substance Use

Partial Hospital Mental Health  Partial Hospital Substance Use

Intensive Outpatient Mental Health  Intensive Outpatient Substance Use

CFIT /AIS  ABA

TMS  HealthPath

|  |  |
| --- | --- |
| **Admission Date:** | **Anticipated Discharge Date:** |
| **Diagnosis Code:** | **Number of Units requested:** |
| **Admitting Clinical Summary** | |

**Notice of Concurrent Request  Medical Necessity Concurrent Request (*FEP and providers not participating with local BCBS)***

*BCBSRI Reviewer will call to complete review telephonically*

|  |  |
| --- | --- |
| **New Anticipated Discharge Date:** | **Number of Additional Units:** |
| **BCBSRI Authorization Number:** |  |
|  | |

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

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