**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:** |