**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:** |