

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

DIRECTIONS: Please select type of notification.
Please Fax to 1-401-459-2503

Member Name:	Member DOB:
Member ID	Authorization # (if applicable)
Requesting Provider Name/ Organization	Address:
Requesting Main Contact and phone #:	UM Contact Fax Number:

Out of Network services Servicing/Facility provider are not participating with his local plan: ☐ Yes ☐ No
Please complete **Facility /Provider** section if you are looking for Out of Network Services Only

Level of Care Services

Please complete **appropriate** section(s) below if you are looking for Level of Care with or without Out of Network Services

Level of Care: Inpatient Services

- ☐ Inpatient Substance Use/ Inpatient Withdrawal Management
- ☐ Medical Board
- ☐ Residential Treatment Substance Use
- ☐ Residential Treatment Mental Health
- ☐ Crisis Stabilization Unit Mental Health
- ☐ Crisis Stabilization Unit Substance Use
- ☐ Inpatient Mental Health

Level of Care: Outpatient Services

- ☐ Partial Hospital Mental Health
- ☐ Partial Hospital Substance Use

Is Servicing/Facility provider participating with his local plan: ☐ Yes ☐ No

Facility /Provider Name:	Facility NPI:
Facility Address:	UM Contact Name:
Facility City, State and Zip Code:	UM Contact Phone Number:
Facility Main phone #:	UM Contact Fax Number:
Notes:	

☐ Notice of Admission Initial Request

***Please note:** This form is used for all lines of business. Federal Employee Program members will require a medical necessity review while Commercial & Medicare lines of business are considered Notifications

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:	

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