Blue Cross Blue Shield of Rhode Island
500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 bcbsri.com

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:
Facility Address:

UM Contact Name and Phone Number:
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 Mental Health
☐ Crisis Stabilization Unit Mental Health
☐ Residential Treatment Mental Health
☐ Partial Hospital Mental Health
☐ Intensive Outpatient Mental Health
☐ CFIT /AIS
☐ TMS
☐ Inpatient Substance Use
☐ Inpatient Withdrawal Management
☐ Crisis Stabilization Unit Substance Use
☐ Residential Treatment Substance Use
☐ Partial Hospital Substance Use
☐ Intensive Outpatient Substance Use
☐ ABA
☐ HealthPath

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

BCBSRI Behavioral Health Case Managers may assist in the coordination of services to provide the quality of care that is customized to assist members in their recovery.

**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*

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☐ **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:

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