**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:**

**Facility Address: UM Contact Phone Number:**

**Facility Main phone #: UM Contact Fax:**

**Facility NPI: 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: 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**

|  |  |
| --- | --- |
| **Admission Date:** | **Anticipated Discharge Date:** |
| **Procedure/CPT if applicable:** | **Number of Units requested:** |
| **Diagnosis Code:** |  |
| **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:** | **Procedure/CPT if applicable/additional codes:** |
|  | |

**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:** | |