Facility Based Behavioral Health

Inpatient, Residential, Partial Hospitalization and IOP Authorization Request

****Chart Notes Required****

Please fax to Behavioral Health: 503-574-8110 | Questions please call:503-488-2800 or 855-722-8205

NOTE: This form cannot be used to request ABA therapy, TMS or outpatient behavioral health services.

Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB:	Phone:
Address:	Date of Admit	Date Span Requested:

Primary Care Physician (PCP):	
Requesting Provider:	TIN#:
Address:	NPI#:
Attending Provider:	TIN#:
Address:	NPI#:
Treating Facility:	TIN#:
Address:	NPI#:

Requested Level of Care/ASAM Level:

OUTPATIENT	RESIDENTIAL	INPATIENT
☐ SUD – Level 2.1 (IOP)	☐ SUD – Level 3.1	☐ Subacute Detox – Level 3.7
☐ SUD – Level 2.5 (PHP)	☐ SUD – Level 3.3	☐ IP Detox – Level 3.7
☐ MH – IOP	☐ SUD – Level 3.5	☐ IP MH
☐ MH – PHP	☐ MH RTC	☐ MH Subacute
☐ MH – Day Treatment		

IOP & Partial Hospitalization # of Units being requested _____ # of Days per Week being requested _____

ICD-10 Code(s):	Revenue/CPT Code(s):

Expedite- defined as member's life, health or ability to regain maximum function is in serious jeopardy if determination is not made in the standard timeframe. **Request must include supporting documentation to substantiate an expedited review.**

Explanation Required:

In-Network Benefits: **Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility. Please also submit facility's state license to provide level of care/service requested.**

Explanation Required:

****REQUIRED** Utilization Review Contact Information:**		
Name:	Phone #:	Fax#: