



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
<input type="checkbox"/> SUD – Level 2.1 (IOP) <input type="checkbox"/> SUD – Level 2.5 (PHP) <input type="checkbox"/> MH – IOP <input type="checkbox"/> MH – PHP <input type="checkbox"/> MH – Day Treatment	<input type="checkbox"/> SUD – Level 3.1 <input type="checkbox"/> SUD – Level 3.3 <input type="checkbox"/> SUD – Level 3.5 <input type="checkbox"/> MH RTC	<input type="checkbox"/> Subacute Detox – Level 3.7 <input type="checkbox"/> IP Detox – Level 3.7 <input type="checkbox"/> IP MH <input type="checkbox"/> MH Subacute
IOP & Partial Hospitalization # of Units being requested _____ # of Days per Week being requested _____		
ICD-10 Code(s):		Revenue/CPT Code(s):
<p><u>Expedite</u>- 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.</p> <p>Explanation Required:</p>		
<p><u>In-Network Benefits</u>: 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.</p> <p>Explanation Required:</p>		
REQUIRED Utilization Review Contact Information:		
Name:	Phone #:	Fax#:

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