



# 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:
<b>Primary Care Physician (PCP):</b>		
<b>Requesting Provider:</b>		TIN#:
Address:		NPI#:
<b>Attending Provider:</b>		TIN#:
Address:		NPI#:
<b>Treating Facility:</b>		TIN#:
Address:		NPI#:
<b>Requested Level of Care/ASAM Level:</b>		
<b>OUTPATIENT</b>	<b>RESIDENTIAL</b>	<b>INPATIENT</b>
<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
<b>Day Treatment, IOP &amp; Partial Hospitalization:</b> # 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. <b>Request must include supporting documentation to substantiate an expedited review.</b></p> <p>Explanation Required:</p>		
<p><u>In-Network Benefits</u>: <b>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.</b></p> <p>Explanation Required:</p>		
<b>**REQUIRED** Utilization Review Contact Information:</b>		
Name:	Phone #:	Fax#:

IMPORTANT NOTICE: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message by error, please notify us immediately and destroy the related message.