**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:** |