

Member information

Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:				DOB (MM/DD/YYYY):
Member ID#:				Member Phone:
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <input type="checkbox"/> Emergent Inpatient Admission			

Referral/Service type requested

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	Previous Auth#:
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary <input type="checkbox"/> Inpatient Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary If Involuntary, Court Date: _____	<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Day Treatment <input type="checkbox"/> Assertive Community Treatment Program <input type="checkbox"/> Targeted Case Management		<input type="checkbox"/> Electroconvulsive Therapy <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Other _____

Please send clinical notes and any supporting documentation

Primary ICD-10 Code for Treatment:			Description:		
Dates of Service Start	Dates of Service Stop	Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

Provider information

Requesting Provider / Facility:					
Provider Name:		NPI#:		TIN#:	
Phone:		Fax:		Email:	
Address:			City:		State: Zip:
PCP Name:			PCP Phone:		
Office Contact Name:			Office Contact Phone:		
Servicing Provider / Facility:					
Provider/Facility Name (Required):					
NPI#:		TIN#:		Medicaid ID# (If Non-Par): <input type="checkbox"/> Non-Par <input type="checkbox"/> COC	
Phone:		Fax:		Email:	
Address:			City:		State: Zip:
For Passport Use Only:					