Behavioral Health Day Treatment Authorization Request Form

Code : H2012

Member Information

Member Name:	Member Medicaid ID#:
Member Date of Birth:	

Provider Information

Treating Provider Name:	Provider NPI:	TIN#
Requestor Information:		
Name:	Phone:	Fax:
Facility Name:	Facility NPI:	

Please include the following with your request:

- **Local Educational Authority with which you have a linkage agreement:**

Are services court ordered : ☐ Yes ☐ No

Details if yes:

Dates of Service		Initial or Concurrent
Start Date:		
End Date:		

Severity = Mild, Moderate, Severe or N/A (Provide a brief description)

Or you may submit Member's biopsychosocial assessment

	Severity	Description
Co-morbid bio-medical or development condition		
Co-morbid substance use disorder		
Cognitive or memory impairment		
Impaired impulse control, judgement or insight		
Other emotional or behavioral disturbance		
Academic achievement as applicable		
Risk of Harm to self or others		

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Additional Information

Please indicate if this an Initial or Concurrent Request

	Yes / No	Description
Signs or symptoms related to admitting diagnosis (or impact of comorbidity on admitting diagnosis) are stable or improving		
Impairments in function are stable or improving		

Indicate Social Determinants of Health Needs

Include the Assessment and Treatment Plan with your request

Discharge Plans

To submit your request to the UM Department :

- **UTILIZE AVAILITY TO SUBMIT YOUR REQUEST**
- **FAX THE CLINICAL REQUEST TO: (833) 454-0641**
- **CALL THE REQUEST: (800) 578-0775**

You may also utilize the Universal Fax form located on our Website