

Instructions: This form should be completed and filled out by the requesting provider. Prior to completing this form, please confirm the patient's benefits, eligibility and whether pre-authorization is required.

Is this for a Medicare Preservice Benefit Organization Determination Request? Yes No

Expedited request. I attest that this request meets the definition indicated below by checking the expedited request box. **Fax to 1 (855) 240-6498.**

Expedited is defined as: When the member or his/her provider believes that waiting for a decision within the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy.

SECTION 1 – PATIENT INFORMATION

Patient Name (Last)				First				MI	Patient's Phone #			
Patient's Regence Member ID #				Group #				Date of Birth				

SECTION 2 – PROVIDER INFORMATION

Please check one: Requesting/Prescribing Provider Rendering/Treating Provider

Provider Name				Tax ID #			
NPI #		Office Phone #		Confidential Voice Mail <input type="checkbox"/> Yes <input type="checkbox"/> No		Fax #	
Mailing Address				City		State	ZIP Code
Provider Specialty				Email Address			

Who should we contact if we require additional information?

Name		Phone #		Confidential Voice Mail		Fax #	
		Ext.		<input type="checkbox"/> Yes <input type="checkbox"/> No			

If a physician reviewer needs a peer to peer discussion before a determination, please provide the treating provider's direct phone number and availability for the next 3 to 5 days.

Phone #:		Date:		Date:		Date:		
Ext:		Time:		Time:		Time:		
Facility Name				Tax ID #		NPI #		
Mailing Address				Fax #				
City		State	ZIP Code		Phone #		Confidential Voice Mail	
					Ext.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Facility Type: <input type="checkbox"/> Freestanding <input type="checkbox"/> Acute				Email Address				

SECTION 3 – PREAUTHORIZATION REQUEST

Date of Services/Anticipated Admission _____

Substance Use Disorders: ASAM Level of Care Requested: 2.0/2.1 2.5 3.5 3.7 4.0

Mental Health Care Requested:

- Inpatient Residential Treatment Partial Hospitalization
 Intensive Outpatient Other, please specify _____

Note: This form does not serve as a notification of admission. Please reference our provider website for instructions about how to notify us of an admission.

Please provide all diagnosis, CPT or HCPCS codes and their descriptions.

Diagnosis code(s) and description(s)	CPT or HCPCS code(s) and description(s)
Primary:	
Second:	
Third:	

SECTION 4 – DOCUMENTATION SUBMISSION

Please submit the following documentation, as appropriate for this request:

Psychiatric or substance use disorder evaluation or intake assessment including:

- Family history
- Medical, psychiatric and substance use history
- Mental status exam
- Personal and social history (psychosocial)
- History of current complaint/clinical status
- Member's current complaint/clinical status

History and physical/nursing assessment (if available) including:

- Current vitals
- Current medical concerns/risks

Substance use disorders only:

- Clinical Institute Withdrawal Assessment (CIWA) or
- Clinical Opiate Withdrawal Scale (COWS) score or
- Description of active withdrawal symptoms

Any other supporting documents you would like considered, such as letters from outpatient providers, etc.