



Authorization Request for Behavioral Health/Substance Treatment

Submit this completed form to _____

Date of Request _____ Number of Pages in this Request _____

Our goal is to provide the most appropriate and timely care for our mutual patients. To this end, "Urgent" is defined as: Medical services that are needed in a timely or urgent manner that would subject the member to adverse health consequences without the care or treatment requested. University of Utah Health plans reserves the right to classify Urgent requests as standard requests when this definition is not met.

Patient Name _____ DOB _____ ID Number _____

Requested Level of Care

Start Date _____ End Date _____

Anticipated/Expected Length of Stay (Treatment) _____

☐ Inpatient Psychiatric Admission ☐ Inpatient Medical Detox/Chemical Dependency

☐ Residential Treatment (Psychiatric/Chemical Dependency) – Number of Beds _____

☐ Partial Hospital Program – Member will be attending _____ days a week.

☐ Intensive Outpatient Program – Member will be attending _____ days a week.

☐ Outpatient Treatment

ICD 10	CPT/REV Codes	Units/Visits	Comments

Requesting Physician _____ NPI _____

Contact Name _____ Phone _____ Fax _____

Address _____



Service Rendering Hospital/Facility _____ NPI _____

Contact Name _____ Phone _____ Fax _____

Address _____ Tax ID _____

Note: Please submit clinical documents with time stamped note, signed by author.

Initial Request – Inpatient Admission/Residential Treatment

- ☐ Inpatient notification to include H&P and all applicable clinical
- ☐ COWS/CIWA/PAWS Scores
- ☐ Barriers to Discharge
- ☐ Admission note from Psychiatrist/Physician (If Applicable)
- ☐ Any adjustments or titrated medications being used
- ☐ Intake Assessment
- ☐ For **Out of Network** Providers/Programs: Copy of State License

Concurrent Review – Inpatient Admission/Residential Treatment

- ☐ Psychiatrist Note
- ☐ All therapy notes for applicable date span
- ☐ Any adjustments or titrated medications being used
- ☐ Updated Treatment Plan, Barriers to Discharge
- ☐ Why does the client continue to need 24 hour monitoring
- ☐ Current CIWA/COWS Scores, Craving Score, Anxiety Score
- ☐ Current withdrawal symptoms
- ☐ Triggers identified
- ☐ Coping skills identified

Submit completed form by fax to 1-559243-7012 or email to

UMFax@healthcomp.com