Basic administrative information for authorization/reauthorization residential substance use disorder treatment

Submission instructions

Please fax completed forms to Coordinated Care of Washington, Inc. at 833-286-1086

Include with your request:
- ASAM Assessment
- Plan of Care
- Summary/Clinical Progress Notes
- Medication Administration Record
- Withdrawal Scales (CWA, COWS, etc.)

HIPAA disclaimer

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1 Submission information

Member patient ID: _____

Authorization request: ☐ Initial authorization ☐ Reauthorization

Treatment type: ☐ Withdrawal management ☐ Non-withdrawal management

_____ _____

Date form completed Admission date

2 Authorization/reauthorization request

_____ to _____

Date from Date to

_____

Level of care requested/ASAM

_____ _____

Proposed HCPC/CPT code (corresponds to level of care) Current authorization number

3 Member information

_____ _____

First name Last name

Sex at birth: ☐ Male ☐ Female Gender identity: ☐ Male ☐ Female ☐ X[1]

_____ _____ _____

Date of birth Phone number Insurance member ID

1 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law.

4 Utilization management (UM)

UM contact name

Contact phone

5 Requesting provider

Requesting provider name

Provider NPI

Requesting facility name

Facility TIN

Facility phone

Facility fax

Facility street address, city, and zip code

6 Servicing provider

Same as requesting provider? ☐ Yes ☐ No
If no, complete the information in this section.

Servicing provider name

Provider NPI

Additional provider NPI

Servicing facility name

Facility TIN

Facility phone number

Facility fax number

Facility street address, city, and zip code

7 Diagnosis

Primary diagnosis code:

Primary diagnosis description