Submit to:
Coordinated Care Utilization Management Department
1145 Broadway, Suite 300, Tacoma, WA 98402
PHONE: 1-877-644-4613
FAX: 1-833-286-1086

KING COUNTY RESIDENTIAL TREATMENT AUTHORIZATION REQUEST FORM - SUD

Please print clearly—incomplete or illegible forms will delay processing. *Required Fields

Date:______________________

*PATIENT INFORMATION	*PROVIDER INFORMATION
*Patient First Name:______________________	*Provider Name:______________________
*Patient Last Name:______________________	*Facility Name:______________________
*DOB:______________________	*Provider NPI:______________________
*SSN:______________________	*TIN #:______________________
*Patient ID:______________________	*Phone:______________________
*Has information been shared with PCP: Yes No	*Fax:______________________
	*Email:______________________

*Requested Facilities

1.______________________ Phone:______________________

2.______________________ Phone:______________________

3.______________________ Phone:______________________

*Authorization Request	*Current ICD Diagnosis
*Procedure Code:______________________	*Primary:______________________
*ASAM Level Requested:______________________	Secondary:______________________
*Units Requested:______________________	Additional:______________________
*Start Date or Admission Date:______________________	Additional:______________________

*Current Risk/Lethality

*Danger to self or others? Yes (If yes, please explain) No

*Mental Health Status Exam (MSE) within Normal Limits? Yes No (If no, please explain)

*Required Attachments

* Current Psychotropic Medications, if applicable

*Initial Assessment/Evaluation/ASAM Assessment

*Current Treatment Plan/Goals

*Current Safety Plan

Any additional documents supporting your request for this level of care

*PROVIDER SIGNATURE: ____________________ DATE: ____________________

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