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

OUTPATIENT/ INPATIENT BEHAVIORAL HEALTH SERVICE AUTHORIZATION REQUEST FORM

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: ____________________

*Service Requested

Prior Authorization Outpatient Treatment Request:

Individual Family Group Interactive Therapy (under age 21 only)

Frequency of visits: ____________________ Units per visit: ____________________

Prior Authorization for Intensive Outpatient/Day Treatment Mental Health/Substance Use

Number of days per week attending: ____________ Number of hours per day: ____________

Prior Authorization: Residential Treatment for Substance Use Disorder or Mental Health

Prior Authorization: Mental Health Inpatient Hospitalization

*Authorization Request	*Current ICD Diagnosis
*Procedure Code: ____________________	*Primary: ____________________
Additional Procedure Code: ____________________	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

*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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