ambetter.

coordinated care
coordinatedcarehealth.com

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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