



Inpatient Auth Request Fax Cover Sheet

Call Provider Line at 800-798-2254, Option 3
Then, fax to 866-220-4495

| Facility Information | |
|---|---|
| Date: | # of Pages (including cover sheet): |
| Client Name: | Hospital Name: |
| Intake Point of Contact: | |
| Phone #: | Fax #: |
| UR Point of Contact: | Facility Type: <input type="checkbox"/> Fee For Service <input type="checkbox"/> Short Doyle |
| Phone #: | Fax #: |
| Admission & Insurance Information (required upon initial request and as changes occur): | |
| Admit Date: | Medi-Cal or SSN: |
| Attending Physician: | Client DOB: |
| Legal Status: (72hr/ 14-day/ 30-day/ T-Con / P- Con/ Voluntary (hold required for SB43)) | San Diego Medi-Cal: <input type="checkbox"/> Yes <input type="checkbox"/> No If Medicare/OHC – Start date of Medi-Cal Coverage: (Must include EOB or Letter of Non-Coverage) |
| Reason for MH Admission: <input type="checkbox"/> DTS <input type="checkbox"/> DTO <input type="checkbox"/> GD/MH <input type="checkbox"/> OTHER OR Reason for SB43 Admission: <input type="checkbox"/> GD/SUD only <u>and</u> <input type="checkbox"/> CDRH or <input type="checkbox"/> IP BHU | |
| Admit Auth | Continued Auth |
| <input type="checkbox"/> MH Admit Auth: # Days requested (up to 3 Acute, up to 1 Admin): Acute #: Start Date Acute: Admin #: Start Date Admin: OR <input type="checkbox"/> SB43 Admit Auth: # Days requested (up to 3 Acute): Acute #: Start Date Acute: Documents Required: <ul style="list-style-type: none"> Complete Face Sheet Admission Orders Initial Plan of Care If MH Admin Day, Disposition Plan/Location – Call Logs (if applicable) | <input type="checkbox"/> MH Continued Auth: # Days Requested (up to 4 Acute, up to 7 Admin): End date of previous authorization: Acute #: Start Date Acute: Admin #: Start Date Admin: OR <input type="checkbox"/> SB43 Continued Auth (for IP BHU Hospital called and no CDRH bed available): <input type="checkbox"/> IP BHU or CDRH (# Days requested (up to 4 Acute, up to 7 Admin): End date of previous authorization: Acute #: Start Date Acute: Admin #: Start Date Admin: Documents Required: <ul style="list-style-type: none"> Continued Plan of Care Additional Information If MH Admin Day, Disposition Plan/Location Call Logs (if applicable) |
| <input type="checkbox"/> Expedited/Informal Appeal or Clinical Consultation (submit within 2 business days of denial fax date) | Discharge |
| First denied date of service(s) on denial (if applicable): If requesting Acute or Admin days, utilize Admit/Continued Auth box Documents Required: <ul style="list-style-type: none"> Updated Plan of Care/Additional Information | <input type="checkbox"/> MH Discharge <input type="checkbox"/> SB43 IP BHU Discharge <input type="checkbox"/> SB43 CDRH Discharge Admission Date: Discharge Date: Dates of Acute Days: Dates of Admin Days: Documents Required: <ul style="list-style-type: none"> Discharge Plan/Summary |

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