



Behavioral Health Inpatient Notification Form Request for Authorization

Please complete all information requested on this form and fax to 1-866-900-6918.

Provider / Facility Name: _____ Number of Pages: _____

Contact Name: _____ Phone Number: _____ Fax Number: _____

Insurance Type: STAR STAR Health (foster care) STAR Kids
 CHIP STAR+PLUS Medicare
 Ambetter COB Other

Type of Request: Admission I/P PHP 912 PHP 913 IOP 905
(please select one for each section) IOP 906 RTC H2035 RTC H0012
 Other Code Types: _____
 Out of Network or Participating

Patient Name: _____ Room Number: _____

Medicaid/Medicare ID Number: _____ Patient DOB: _____

UR Name: _____ UR Number: _____

Provider NPI: _____ Facility NPI: _____

Provider Tax ID: _____ Facility Tax ID: _____

Address: _____

Admission Date: _____ Admitting DX/ codes: _____

Physician Name: _____ Physician Phone: _____

Clinical information for medical necessity attached and faxed: Yes No