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:
(please select one for each section)
☐ Admission I/P ☐ PHP 912 ☐ PHP 913 ☐ IOP 905
☐ 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

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