Utilization Review for New Inpatient/Residential Behavioral Health Services

This request is only to be used for **NEW INPATIENT/RESIDENTIAL BEHAVIORAL HEALTH SERVICES.**

Client Information

Patients Name:

Patients Address:

ID #:

Policy Holder's Name:

Admission Date:

Admission Diagnosis:

Patient Date of Birth:

Patients Phone #:

Group #:

Level of Care:

☐ Inpatient MH ☐ Residential MH
☐ Inpatient CD ☐ Residential CD
☐ Inpatient ED ☐ Residential ED
☐ Detoxification

Patient Presented to Hospital program:

☐ On Own ☐ By Police/Ambulance
☐ Transferred from Another Hospital
☐ With Family / Friend

Patient Is:

☐ Voluntary ☐ On 72 Hour Hold
☐ Suicidal ☐ Homicidal
☐Delusional ☐ Hallucinating

Provider Information

Service and # of Days Requested

Name of Hospital/Clinic/Organization

Hospital/Clinic/Organization Address

Attending Provider/Clinician and Credentials

Name of Requestor/Requestors Phone #

Requestor's email address and Fax #

Clinical information must accompany request to authorize services. Request will take 1-3 business days to process.

Submit completed form to team@startwithteam.com or fax to 651-642-1809

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