

# Authorization request for Behavioral Health/Substance Treatment



**Email:** [uuhptransition@hsc.utah.edu](mailto:uuhptransition@hsc.utah.edu)  
(Please send email encrypted to protect PHI)  
**Phone:** 801-587-6480 Option #2  
**Fax:** 801-213-2132

Date of request: \_\_\_\_\_  
No. pages included in this request: \_\_\_\_\_

Our goal is to provide the most appropriate and timely care for our mutual patients. To this end, "**Expedited**" is defined as: Medical services that are needed in a timely or urgent manner that would subject the member to adverse health consequences without the care or treatment requested. University of Utah Health plans reserves the right to classify Expedited requests as standard requests when this definition is not met.

For a better experience, if you are a contracted provider, we invite you to register to our provider portal. If not, please use our website to submit your request directly.

<https://apps.uhealthplan.utah.edu/UHealthPlansForms/Authorization/Create>

Patient Name: \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ID# \_\_\_\_\_

Requested Level of Care			
Start Date: _____		End Date: _____	
Anticipated/Expected Length of Stay (Treatment): _____			
<input type="checkbox"/> Inpatient Psychiatric Admission <input type="checkbox"/> Inpatient Medical Detox /Chemical Dependency			
<input type="checkbox"/> Residential Treatment (Psychiatric/Chemical Dependency)—Number of beds _____			
<input type="checkbox"/> Partial Hospital Program. Member will be attending _____ days a week.			
<input type="checkbox"/> Intensive Outpatient Program. Member will be attending _____ days a week.			
<input type="checkbox"/> Social Detox (Medicaid plans only) <input type="checkbox"/> Outpatient Therapy			
ICD-10	CPT/REV Codes	Units/Visits	Comments

Requesting Physician: \_\_\_\_\_ NPI \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

Service Rendering Hospital/Facility: \_\_\_\_\_ NPI: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_ Tax ID: \_\_\_\_\_

## Initial Request

### For all BH admissions requests (if applicable)

	For all <b><u>Out of Network</u></b> Providers/Programs: Copy of State License
	Inpatient notification to include H&P and all applicable clinical
	COWS/CIWA/PAWS Scores
	Barriers to discharge
	Admission notes from Psychiatrist/Physician (if applicable)
	Any adjustments or titrated medications being used
	Intake Assessment
	Schedule for PHP, IOP and RTC Initial reviews

## Concurrent Review

### For all BH admissions requests (if applicable)-Last 7 to10 days

	Psychiatrist Note
	All therapy notes for applicable date span
	Any adjustments or titrated medications being used
	Updated treatment goal plan and treatment plan review
	Current CIWA/COWS/PAWS Scores. ASAM Assessment.
	Post-Discharge plan

## Residential Treatment Review (Adolescences)

	Accommodations for continuing education of school aged members recognized by an educational accreditation organization such as the State Board of Education or the National School Accreditation Board
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