Basic administrative information for authorization/reauthorization residential substance use disorder treatment

Submission instructions

HIPAA disclaimer

1	**Submission information**

Member patient ID:

Authorization request: Initial authorization Reauthorization

Treatment type: Withdrawal management Non-withdrawal management

Date form completed Admission date

2	**Authorization/reauthorization request**

to

Date from Date to

Level of care requested/ASAM

Proposed HCPC/CPT code (corresponds to level of care) Current authorization number

3	**Member information**

First name Last name

Sex at birth: Male Female Gender identity: Male Female X[1]

Date of birth Phone number Insurance member ID

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1 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law.

4	**Utilization management (UM)**

UM contact name

Contact phone

5	**Requesting provider**

Requesting provider name

Provider NPI

Requesting facility name

Facility TIN

Facility phone   Facility fax

Facility street address, city, and zip code

6	**Servicing provider**

Same as requesting provider?   Yes   No
If no, complete the information in this section.

Servicing provider name

Provider NPI

Additional provider NPI   Servicing facility name

Facility TIN   Facility phone number   Facility fax number

Facility street address, city, and zip code

7	**Diagnosis**

Primary diagnosis code:
Primary diagnosis description