



ADULT
SUD RESIDENTIAL AUTHORIZATION REQUEST
FAX COVER SHEET
(To be faxed to 855-244-9359)

Date Faxed:	Program Name:	Point of Contact:
Phone Number:	Fax Number:	# of Pages Included:
<u>All Requests:</u> Requested Level of Care: 3.1 <input type="checkbox"/> 3.5 <input type="checkbox"/> Requested Start Date: PO Referral for Assessment/Treatment? Yes <input type="checkbox"/> No <input type="checkbox"/> Court Order for Residential? Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/> <u>Other Health Coverage:</u> If this is 1 st request with client having other health coverage (OHC)/ private insurance, which of the following has been included? <input type="checkbox"/> Evidence of Coverage or Letter of Non-Coverage <p style="text-align: center;">OR</p> <input type="checkbox"/> A signed AOB and 42 CFR Part 2 compliant Release of Information (ROI) Form <p style="text-align: center;">OR</p> <input type="checkbox"/> Client refused to sign ROI to bill OHC
<input type="checkbox"/> <u>Initial:</u> Date & Time Request Called In: <input type="checkbox"/> SUD Residential Authorization Request		<input type="checkbox"/> <u>Continuing:</u> <input type="checkbox"/> Adult ASAM Criteria Assessment <p style="text-align: center;">&</p> <input type="checkbox"/> Date of Birth: <p style="text-align: center;">OR</p> <input type="checkbox"/> SUD Residential Authorization Request
<input type="checkbox"/> <u>Extension:</u> <input type="checkbox"/> SUD Residential Authorization Request		<input type="checkbox"/> <u>Level of Care Change:</u> <input type="checkbox"/> Adult ASAM Criteria Assessment & <input type="checkbox"/> Date of Birth: <p style="text-align: center;">OR</p> <input type="checkbox"/> SUD Residential Authorization Request
<div style="text-align: center;"><input type="checkbox"/> <u>Discharge:</u></div> <div style="text-align: center;"><input type="checkbox"/> Discharge Plan/Summary <input type="checkbox"/> Discharge Date:</div>		

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