Authorization Request Form

Behavioral Health Inpatient Admission

Patient's Name: ___________________________________ DOB: __/__/__ ID# _____________________

***Attach H&P and clinical information including medications and fax all to (715) 852-5738.**

Note: Discharge summary including follow up care information is required at time of discharge.

Diagnosis Code(s):

____

____

____

Type of Admission

- ☐ Chapter 51/Emergency Detention
- ☐ Mental Health
- ☐ Detox

Date of Admission __/__/__ Estimated Length of Stay: _____ Actual D/C Date: __/__/__

Brief Summary of Current Clinical Status/Admission Information:

____

____

____

Provider Name: ____

Facility Name: ____ NPI: __________________

Address: ____ Tax ID: __________________

Contact Name: _________________________ Phone: ______________ Fax: ____________

The submission of supporting clinical documentation/plan of care is required with this form.

Privacy and Confidentiality:
The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at 866-364-0892 and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.