Trilogy
Homegrown Health Care

Authorization Request Form

Behavioral Health Inpatient Admission

Patient's Name:_____DOB:__/__/__ID# _____

***Attach H&P and clinical information including medications and fax all to 608-245-3097.**

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.