



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.

Privacy and Confidentiality:
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