PriorityHealth

Behavioral Health inpatient authorization form

Fax to: 616.975.0249

Missing or incomplete information including required clinical documentation (when required) may result in a delay in reviewing request.

Facility information

Facility name _____

Service address _____

Provider tax ID _____ Provider NPI _____

Facility contact information of reviewer requesting authorization

Name/Title _____

Address _____

Phone _____ Fax: _____

Comments _____

Type of request:

☐ Initial assessment/Review (attach clinical documentation, Priority Health Clinician will contact you to complete authorization process)
☐ Concurrent review (attach clinical documentation)
☐ Retrospective review (attach clinical documentation)
☐ Discharge (provide discharge information below)
☐ Medicare organization determination

Level of care

☐ MH inpatient ☐ MH residential ☐ MH partial hospitalization ☐ SUD sub-acute detox
☐ SUD residential ☐ SUD partial hospitalization

Dates of service requested: From: _____ To: _____

Attending psychiatrist name _____

Member information

Last name _____ First name _____

Priority Health ID # _____ Date of birth _____

Member phone _____

☐ **Discharge only**

Discharge date _____

Diagnosis _____

Discharge medications (include name, dosage and frequency)

_____

_____

_____

Follow-up care

Psychotherapy _____

Psychiatry or PCP _____

Other _____

Was member referred to Care Transitions? ☐ Yes ☐ No

If no, please explain: _____