

# Inpatient Prior Authorization Form



Evernorth Behavioral Health provider website: [Provider.Evernorth.com](https://Provider.Evernorth.com)

This form is only for initial requests for inpatient behavioral and substance use services, including mental health, detox, substance use rehabilitation, dual diagnosis, and eating disorder treatment. **For other higher levels of care, including residential and partial hospitalization, please call 800.926.2273.**

This authorization request form should be completed by the clinician who has knowledge of the Evernorth customer's current clinical presentation and treatment history. *Please note: Evernorth may release the information contained in this form to the customer or the customer's representative.*

**Please complete this form and fax it to 833.213.9320.**

If you are unable to submit your requests via fax, please call 800.926.2273 for authorization.

## TIPS FOR COMPLETING THIS FORM:

- Verify coverage prior to submitting this request.
- To help expedite processing, please complete all sections as **specifically** and **clearly** as possible.
- Typed responses are preferred.
- Omissions, generalities, and illegibility may result in this request being returned for completion or clarification.
- Please note that Evernorth assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information. It is your responsibility to take any steps necessary to protect the email or documents prior to receipt by Evernorth.

1. **Level of care requested:**  Inpatient mental health  Inpatient detox  Inpatient substance use rehabilitation  
 Inpatient dual diagnosis  Inpatient eating disorder treatment

2. **Date of admission to behavioral unit:** \_\_\_ / \_\_\_ / \_\_\_  
Admission status to behavioral unit:  Waiting  Admitted

3. **Name of primary contact for initial request:** \_\_\_\_\_  
Direct telephone number: \_\_\_\_\_  
Fax number (for follow up/authorization information): \_\_\_\_\_

4. **Patient information**  
Patient name: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Patient date of birth: \_\_\_ / \_\_\_ / \_\_\_  
Patient current home address: \_\_\_\_\_

Last four digits of the policyholder's social security number (optional): \_\_\_\_\_

Is the patient their own guardian? \_\_\_\_\_  
a. If yes, please provide patient's telephone number: \_\_\_\_\_  
b. If no, please provide parent/guardian name: \_\_\_\_\_  
Parent/guardian telephone number: \_\_\_\_\_

5. **Facility information**  
Requesting facility name: \_\_\_\_\_  
Requesting facility Taxpayer Identification Number (TIN): \_\_\_\_\_  
Requesting facility servicing address: \_\_\_\_\_

### If the requesting and servicing facilities are not the same, please complete the following:

Servicing facility name: \_\_\_\_\_  
Servicing facility Taxpayer Identification Number (TIN): \_\_\_\_\_  
Servicing facility servicing address: \_\_\_\_\_

**6. For out-of-network facilities, is this a network exception request (NER)?** \_\_\_\_\_

Note: Depending on the account, an NER may not apply.

If yes, what is the clinical rationale for requesting the NER?

\_\_\_\_\_  
Please describe if any clinical treatment specialties are relevant for this patient and would be uniquely available from this facility as opposed to another facility in our existing network.

\_\_\_\_\_  
If no, is the customer aware they are using out of network benefits? \_\_\_\_\_

**7. Attending provider (MD-level) information**

Provider name: \_\_\_\_\_

Provider facility Taxpayer Identification Number (TIN) or National Provider Identifier (NPI): \_\_\_\_\_

**8. Utilization review (UR) contact for continued stay reviews**

Contact name: \_\_\_\_\_

Contact telephone number: \_\_\_\_\_

Contact fax number: \_\_\_\_\_

**9. Has the patient been admitted through the emergency room (ER)?** \_\_\_\_\_

If yes, please provide the following information:

Date of ER admission: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Time of ER admission (please specify a.m. or p.m.): \_\_\_\_\_; \_\_\_\_\_

Is the patient medically cleared for transfer? (applicable to out-of-network facilities only) \_\_\_\_\_

**10. Is a bed search needed?** \_\_\_\_\_

**11. Behavioral diagnosis code(s); begin with primary diagnosis code:**

**12. Is this an involuntary admission?** \_\_\_\_\_

**13. Inpatient mental health clinical questions (all questions need to be answered)**

Does the patient have a current suicide plan with an inability to ensure their safety outside of the facility? \_\_\_\_\_

If yes, what is the suicide plan?

\_\_\_\_\_  
Has the patient attempted suicide within the past 72 hours? \_\_\_\_\_

Does the patient have a current plan to harm someone else? \_\_\_\_\_

If yes, what is the plan?

\_\_\_\_\_  
Is the patient at risk due to hallucinations, delusions, or other psychotic activity? \_\_\_\_\_

Inpatient mental health days requested: \_\_\_\_\_

**14. Inpatient detox clinical question**

Is the patient at risk due to physical substance use withdrawal symptoms? \_\_\_\_\_

**Submitter signature:** \_\_\_\_\_

Today's date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Type/print submitter name: \_\_\_\_\_

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