

**Behavioral Health Inpatient Facility (BHIF), Behavioral Health Residential Facility (BHRF), Therapeutic Foster Care for Children (TFC) and Substance Use Disorder (SUD BHRF) Prior Authorization and Continued Stay Request Form**



**INSTRUCTIONS:** Forms must be typed. Fax completed forms and required documents to HCA Behavioral Health Utilization Department. **Fax to 480-760-4732.**

**Prior authorization and approval is required prior to admission.**

Date of Request: _____	Prior Authorization
Requested Service Level:	Continued Stay
Behavioral Health Inpatient Facility for persons under 21	Standard (up to 14 calendar days)
Behavioral Health Residential Facility	Expedited (up to 72 hours)* All BHRF requests
Therapeutic Foster Care	SUD Behavioral Health Residential Facility
<i>Authorization # required for Continued Stay Requests</i>	
Facility Name: _____	Tax ID _____
NPI: _____	Telephone _____
Requestor: _____	Email _____
FAX: _____	
Behavioral Health Home/ Outpatient Provider: _____	
Physician Name: _____	Phone #: _____
E-mail: _____	

Member Name: _____	Age: _____	Gender: _____
AHCCCS ID: _____		
DOB: _____	Population: <input type="checkbox"/> T19 <input type="checkbox"/> NT19 <input type="checkbox"/> SMI <input type="checkbox"/> CMDP	

ICD 10 Diagnosis code and narrative (Complete for initial and continued stay request):

1.Code: _____	Narrative: _____
2.Code: _____	Narrative: _____
3.Code: _____	Narrative: _____

Current Location of Member

What is the reason for the prior authorization or continued stay request ?

Describe members's current symptoms and behaviors requiring this service?

What is the Aftercare plan and placement after discharge?

Additional information

**Required Supporting Documentation**

(CON) Certificate of Need for BHIF Admissions and  
(RON)Recertification of Need for Continued Stay Reviews  
CFT/ART Notes indicating need or continued need for  
service Current Psychiatric and Psychosocial Evaluation  
Medication Sheets

ASAM or substance abuse if applicable  
Current Treatment Plan  
Any other relevant clinical information