Fax completed form to **616.975.0249** Questions? Call our Provider Helpline at 800.942.4765. Priority Health

Behavioral health prior authorization form

Missing or incomplete information, including required clinical documentation, may result in delays.

Date: _____

Type of service:

☐ Initial – *attach clinical documentation*		
☐ Concurrent review – *attach clinical documentation*	Authorization #	
☐ Discharge – *provide discharge information below*	Authorization #	
☐ Retrospective review – *attach clinical documentation*	Authorization #	
☐ Medicare organization determination		

Member information

Member last name		Member first name	
Priority Health ID#		Date of birth	
Phone #			

Level of care

☐ MH Inpatient
☐ MH Residential
☐ MH Partial Hosp.
☐ MH IOP
☐ MH OP
☐ SUD Detox
☐ SUD Residential
☐ SUD Partial Hosp.
☐ SUD IOP
☐ SUD OP
☐ Check box if you have 24/7 on-site nursing for residential levels of care. If no, explain why in the Additional Information field below. Please note "on-site" does not mean "on call."

Date(s) of service	From:	To:	
SW/case manager name		Discharge date – *if applicable*	
SW/case manager phone #		Attending psychiatrist	
Diagnosis code(s)		Procedure code(s)	

Provider / facility information

Provider name		Facility name	
Provider TIN		Facility TIN	
Provider NPI		Facility NPI	
Address			

Contact

Name		Title	
Phone		Fax	

Additional information / discharge medications – *name, dose, frequency*

Print

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