**ADULT**

**RSUD AUTH REQUEST FAX COVER SHEET**

(To be faxed to 855-244-9359)

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| --- | --- | --- | --- |
| Date Faxed: | Program Name: | | Point of Contact: |
| Phone Number: | Fax Number: | | # of Pages Included: |
| **All Requests:**  Requested Level of Care: 3.1  3.5  Requested Start Date:  PO Referral for Assessment/Treatment? Yes  No  Court Order for Residential? Yes  No | | **Other Health Coverage:**  If this is 1st request with client having other health coverage (OHC)/ private insurance, which of the following has been included?  Evidence of Coverage or Letter of Non-Coverage  **OR**  A signed AOB and 42 CFR Part 2 compliant Release of Information (ROI) Form  **OR**  Client refused to sign ROI to bill OHC | |
| **Initial:**  Date & Time Request Called In:  SUD Residential Authorization Request | | **Continuing:**  Adult ASAM Criteria Assessment  **&**  Date of Birth:  **OR**  SUD Residential Authorization Request | |
| **Extension:**  SUD Residential Authorization Request | | **Level of Care Change:**  Adult ASAM Criteria Assessment  **&**  Date of Birth:  **OR**  SUD Residential Authorization Request | |
| **Discharge:**  Discharge Plan/Summary  Discharge Date: | | | |

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