**ADOLESCENT**

**RSUD AUTH REQUEST FAX COVERSHEET**

(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:  [ ]  Initial Level of Care Assessment **OR** [ ]  SUD Residential Authorization Request |  **Continuing:** [ ]  Initial Level of Care Assessment **OR** [ ]  SUD Residential Authorization Request |
|  **Extension:** [ ]  Initial Level of Care Assessment **OR** [ ]  SUD Residential Authorization Request |  **Level of Care Change:** [ ]  Initial Level of Care Assessment  **OR** [ ]  SUD Residential Authorization Request |
| **Discharge:**[ ]  Discharge Plan/Summary [ ]  Discharge Date: |

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