**ADOLESCENT**

**RSUD AUTH REQUEST FAX COVER SHEET**

(To be faxed to 855-244-9359)

**Please request/enroll client in SmartCare Client Programs prior to faxing any authorization requests.**

|  |  |  |
| --- | --- | --- |
| Date Faxed: Enter text here | Program Name: Enter text here | Point of Contact: Enter text here |
| Phone Number: Enter text here | Fax Number: Enter text here | # of Pages Included: Enter text here |
| **All Requests:** Requested Level of Care: 3.1 [ ]  3.5 [ ]  Requested Start Date: Enter text here 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: Enter text here [ ]  SUD Residential Authorization Request or Initial Level of Care Assessment [ ]  **Proof of insurance or** [ ]  **no insurance**[ ]  **Request/Enroll Client to SmartCare Client** **Programs**  | [ ]  **Continuing:**  [ ]  SUD Residential Authorization Request or Initial Level of Care Assessment[ ]  **If needed, request/enroll Client to SmartCare Client** **Programs**  |
| [ ]  **Extension:**  [ ]  SUD Residential Authorization Request or Initial Level of Care Assessment[ ]  **If needed, request/enroll Client to SmartCare** **Client Programs**  | [ ]  **Level of Care Change:**  [ ]  SUD Residential Authorization Request or Initial Level of Care Assessment[ ]  **Request/Enroll Client to new level of care in SmartCare** **Client Programs**   |
|  [ ]  **Discharge:**  [ ]  Discharge Plan/Summary [ ]  Discharge Date: Enter text here |

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