**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 | | | |

**Notice of Disclosure and Confidentiality**

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