Optum

ADOLESCENT
SUD RESIDENTIAL AUTHORIZATION REQUEST
FAX COVER SHEET

(To be faxed to 855-244-9359)

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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