Inpatient Prior Authorization Form

EVERNORTH℠

CLEAR FORM

Evernorth Behavioral Health provider website: Provider.Evernorth.com

This authorization request form should be completed by the clinician who has knowledge of the Evernorth customer's current clinical presentation and treatment history. *Please note: Evernorth may release the information contained in this form to the customer or the customer's representative.*

Please complete this form and fax it to 833.213.9320.

If you are unable to submit your requests via fax, please call 800.926.2273 for authorization.

TIPS FOR COMPLETING THIS FORM:

- Verify coverage prior to submitting this request.
- To help expedite processing, please complete all sections as **specifically** and **clearly** as possible.
- Typed responses are preferred.
- Omissions, generalities, and illegibility will result in this request being returned for completion or clarification.
- **Do not attach full clinical details to this request.** If full clinical information is needed, a clinician will contact you.
- Please note that Evernorth assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information. It is your responsibility to take any steps necessary to protect the email or documents prior to receipt by Evernorth.

1. **Level of care requested:** ☐ Inpatient mental health ☐ Inpatient detox ☐ Inpatient substance abuse rehabilitation ☐ Inpatient dual diagnosis ☐ Inpatient eating disorder treatment

Please note: This form is only for initial requests for inpatient behavioral and substance abuse services, including mental health, detox, substance abuse rehabilitation, dual diagnosis, and eating disorder treatment. For other higher levels of care, including residential and partial hospitalization, please call 800.926.2273.

2. **Date of admission to behavioral unit:** ____ / ____ / _____

   Admission status to behavioral unit: ☐ Waiting ☐ Admitted

3. **Name of primary contact for initial request:** _____

   Fax number *(for follow up/authorization information)*: _____ Direct telephone number: _____

4. **Patient information**

   Patient name: _____ Patient ID: _____ Patient date of birth: ____ / ____ / _____

   Patient current home address:

   _____

   Last four digits of the policyholder's social security number *(optional)*: _____

   Is the patient their own guardian? _____

   a. If yes, please provide patient's telephone number: _____

   b. If no, please provide parent/guardian name: _____

      Parent/guardian telephone number: _____

5. **Facility information**

   Requesting facility name: _____

   Requesting facility Taxpayer Identification Number (TIN): _____

   Requesting facility servicing address:

   _____

   If the requesting and servicing facilities are not the same, please complete the following:

   Servicing facility name: _____

   Servicing facility Taxpayer Identification Number (TIN): _____

   Servicing facility servicing address:

   _____

6. **For out-of-network facilities, is this a network exception request (NER)?** _____

Note: Depending on the account, an NER may not apply.

If yes, what is the clinical rationale for requesting the NER?

_____

Please describe if any clinical treatment specialties are relevant for this patient and would be uniquely available from this facility as opposed to another facility in our existing network.

_____

If no, is the customer aware they are using out of network benefits? _____

7. **Attending provider (MD-level) information**

Provider name: _____

Provider facility Taxpayer Identification Number (TIN) or National Provider Indenifier (NPI): _____

8. **Utilization review (UR) contact for continued stay reviews**

Contact name: _____

Contact telephone number: _____

Contact fax number: _____

9. **Has the patient been admitted through the emergency room (ER)?** _____

If yes, please provide the following information:

Date of ER admission: ____ / ____ / _____

Time of ER admission *(please specify a.m. or p.m.)*: _____; _____

Is the patient medically cleared for transfer? *(applicable to out-of-network facilities only)* _____

10. **Is a bed search needed?** _____

11. **Behavioral diagnosis code(s); begin with primary diagnosis code:**

_____

12. **Is this an involuntary admission?** _____

13. **Inpatient mental health clinical questions *(all questions need to be answered)***

Does the patient have a current suicide plan with an inability to ensure their safety outside of the facility? _____

If yes, what is the suicide plan?

_____

Has the patient attempted suicide within the past 72 hours? _____

Does the patient have a current plan to harm someone else? _____

If yes, what is the plan?

_____

Is the patient at risk due to hallucinations, delusions, or other psychotic activity? _____

14. **Inpatient detox clinical question**

Is the patient at risk due to physical substance use withdrawal symptoms? _____

Submitter signature: _____ Today's date: ____ / ____ / _____

Type/print submitter name: _____

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