Notfication of SUD Admission

Within 24 hours of Admission, please fax to 1.866.535.6974

MEMBER INFORMATION

Member Name: _____ DOB: _____

Member Contact Number: _____ Member Medicaid Number: _____

FACILITY INFORMATION

Facility: _____ Facility UR: _____

ADMISSION/DIAGNOSIS

☐ Voluntary ☐ Court Order ☐ Residential Treatment ☐ Intensive Outpatient Program

☐ H0018 ☐ H2034 ☐ T1006

Admission Date: _____ Estimated Discharge Date: _____

Principle Diagnosis (include DSM V code): _____

Additional Diagnostic Considerations (include DSM V code): _____

_____ _____

_____ _____

Outpatient Therapist: _____ Phone: _____

Outpatient Psychiatrist: _____ Phone: _____

Primary Care: _____ Phone: _____

_____ _____

Staff Signature (with Credentials) Date