HIGHMARK | HIGHMARK

Behavioral Health Utilization Management Authorization Request Form

Submission Instructions: Only One Patient Per Fax. Please print all information.
IMPORTANT! LIMIT FAXED INFORMATION TO JUST RELEVANT CLINICAL INFORMATIOM THAT SUPPORTS MEDICAL NECESSITY FOR THE REQUEST. DO **NOT** FAX THE ENTIRE CLINICAL RECORD.
FOR NY PROVIDERS, PLEASE INCLUDE LOCADTR AND TWO-DAY NOTIFICATION FORMS IF APPLICABLE.

Please fax completed form to Clinical Services:

BEHAVIORAL HEALTH (PA AND DE): 877-650-6112
BEHAVIORAL HEALTH NEW YORK: 833-581-1866

Name of Requestor/Contact Person with Phone Number:			
Is this a request for an out of network gap exception?	☐Yes ☐No		
Patient Name:			
Patient Date of Birth (mm/dd/yyyy):			
Patient ID/UMI Number (with Prefix):			
Name of Requestor/Contact Person:			
Requesting Provider Name:			
Requesting Provider NPI:		**Requesting Provider BSID:**	
Requesting Provider Address	**Street:**		
	City:		
	State:	**Zip Code:**	
Requesting Provider Phone Number:			
Requesting Provider Fax Back Number:			
Primary Diagnosis Code(s):			
Inpatient Admission Date or Start of Care Date (mm/dd/yyyy):			
Type of review	☐**Precertification** ☐**Concurrent Review** ☐**Step Down**		
Level of Care:	☐Inpatient Psychiatric ☐Psychiatric Residential ☐Withdrawal Management ☐Residential-Rehab (Substance Use) ☐Outpatient:		
Admitting Facility Name:			
Admitting Facility NPI:		**Facility BSID:**	
Admitting Facility Address:	**Street:**		
	City:		
	State:	**ZIP Code:**	
Admitting Facility Phone Number:			
Admitting Facility Fax Number:			
Servicing Physician/Provider Name:			

Updated 06.21.2024