



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:

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