Substance Use Disorder Services Notification/Authorization Request Form

COMMUNITY HEALTH PLAN of Washington™
The power of community

Fax for to: 206-652-7067
Medicaid 1-800-440-1561
Medicare 1-800-942-0247
Cascade Select 1-866-907-1906

PLEASE TYPE or WRITE LEGIBLY or this request will be returned as unable to process

MEMBER INFORMATION			
First Name:	Last Name:	MI:	Date of Birth:
Member ID:	Member Address:	Phone #:	
If retroactively enrolled, provide enrollment date:			

ORDERING PROVIDER INFORMATION			
Agency Name:	Contact Person:	Contact Phone Info:	Contact Fax:
Contact Person at this office:	☐ Ordering provider is PCP: PCP's Clinic Name:	☐ Ordering provider is Specialist Specialty:	

PROVIDER INFORMATION	
Provider Group/Clinic:	Contact:
Phone:	Fax:
Street Address:	City | State | Zip:
Provider ID/NPI:	
AUTHORIZATION REQUEST START DATE:	
ESTIMATED DURATION OF THIS EPISODE OF CARE:	
Please indicate CLINICAL urgency of request: ☐ Routine ☐ Urgent	

SERVICE PROVIDER INFORMATION				
Facility Name:		Facility Address:		
☐ Participating: ☐ Non-Participating	TAX ID: NPI:	Specialty:	Contact Name:	Contact Fax:

DIAGNOSES (Primary and any applicable co occurring diagnoses)
1.
2.
3.
4.

ASAM LEVEL OF CARE REQUESTED					
◯	ASAM Level 2.1 | Intensive Outpatient (IOP)	◯	ASAM Level 3.1 | Clinically Managed Low-Intensity Residential Services	◯	ASAM Level 3.3- 3.5 | Clinically Managed High-Intesnity Residential Services
◯	ASAM Level 3.7 | Medically Monitored Inpatient Services	◯	ASAM Level 4 | Medically Managed Inpatient Services	◯	Other

ASSESSMENT AND LEVEL OF CARE
☐ Requested documentation: ASAM Clinical assessment based on level of care requested

Based on the clinical review, please indicate the ASAM recommended level of care:					
◯	Level 2.1	◯	Level 3.7	◯	Level 3.3 - 3.5
◯	Level 4	◯	Other		

Is the ASAM recommended level of care different than what is requested?	☐ Yes ☐ No
If yes, please provide the reason for the variance and include supporting clinical documentation:	

SIGNATURE	
Reviewer Name (print):	
Signature/Credential:	**Date:**