



BEHAVIORAL HEALTH RESIDENTIAL FACILITY ADMISSION NOTIFICATION FORM

◇ Mandatory fields must be completed or information will be returned.



AHCCCS does not require authorization when Medicare or other insurance is primary.

MEMBER ADMISSION REQUESTED

Behavioral Health Residential Facility

AIHP

GR TRBHA

NN TRBHA

PY TRBHA

WM TRBHA

Other

ONE MEMBER AND PROVIDER PER FORM, PER SUBMISSION PLEASE

◇ RECIPIENT NAME:	◇ AHCCCS ID (9 digits): A
◇ PROVIDER NAME:	◇ PROVIDER NPI (10 digits):
◇ PROVIDER PHONE #:	◇ AHCCCS ID (6 digits):
◇ PROVIDER FAX #:	◇ DATE OF ADMISSION:
◇ DIAGNOSIS:	◇ REFERRING PROVIDER:
◇ REASON FOR ADMISSION:	

Notification of admission to AHCCCS is required for initial coverage of up to 5 days of care. During this period, the BHRF is responsible for submitting a Prior Authorization request and ensuring compliance with the criteria listed in AMPM 320-V. If the Prior Authorization request and supporting documents are not received within the initial 5 days of admission, subsequent claims might be denied.

Admission documentation needed for authorization beyond the initial 5 days (all criteria for admission still must be met from the admission date):

- a. Evaluation to determine Behavioral Health Condition and Diagnosis. Evaluation should be recent, and not older than 1 year. Done by a BHP, or by BHT and cosigned by a BHP, utilizing standardized instrument that is able to determine the appropriate level of care.
- b. Treatment Plan - done by the Inpatient/Outpatient or TRBHA Treatment Team. Included in the plan should be an intervention specifying the BHRF level of care as necessary for the member as a least restrictive level of care required to treat the Behavioral Health Condition, identified in the Evaluation. This plan shall not be older than 3 months from the request submission date.

Prior Authorization Request shall be submitted on the AHCCCS Online Provider Portal, please see:
<https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/submissionprocess.html>

For guidelines related to requirements for prior authorization and its accompanying documentation, please refer to:
<https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html>

Return fax # **BHS** (602) 253-6695

If this form was received in error, please contact the Provider immediately at the Provider phone number above.

(Revised 7.5.2023)