Salish Behavioral Health Organization
Substance Use Disorder Treatment Extension Authorization Request

***Fax requests to CommCare at 816-299-4641 or submit via encrypted email to requests@commcare1.org**

Agency Name		Agency NPI #		Salish BHO Provider #	

Date and time of Authorization request	Date:		Time:	
Date of Termination (if requesting discharge)				
Termination reason (if requesting discharge)				
Name and title of person making request				
Requesting agency's email address				
Client Name		DOB		ID #
Client's preferred language	English ☐	Spanish ☐	Other ☐	Language:
Client's mailing address				
Client's Funding Source	Medicaid ☐ Provider One ID:		Non-Medicaid ☐	
Current Authorization Start Date		Last Covered day of services		
Current CommCare Authorization Number				
Current DSM-5 Diagnosis		Current ASAM LOC		

Provide Evaluation of the effectiveness of services provided during current Authorization period	
DIM	
Dim-1	
Dim-2	
Dim-3	
Dim-4	
Dim-5	
Dim-6	

Provide justification for continuation of services	
DIM	
Dim-1	
Dim-2	
Dim-3	
Dim-4	
Dim-5	
Dim-6	

Level of Care Client will continue to receive			
Requested length of extension		ASAM LOC	
Comments:			
COMMCARE to complete below			
CommCare originated Authorization #			
Approved length of extension		ASAM LOC	
Extension start date		Last covered day of services	
Date and time individual is notified			
Signature of CommCare Rep:			