Salish Behavioral Health Organization

Out of Network Provider

Substance Use Disorder Residential Treatment Authorization Request

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

CommCare toll free 877-777-1388

Agency Name		Agency NPI #		Salish BHO Provider #	
Date and time of Authorization request		Date:		Time:	
Date and time of Assessment		Date:		Time:	
Name and title of person making request					
Requesting agency's email address					
Client Name		DOB		ID #	
Client's preferred language	English ☐	Spanish ☐	Other ☐	Language:	
Race (enter code)		Hispanic Origin (Enter Code)		Gender (enter code)	
Sexual Orientation (enter code)					
Client's mailing address					
Client's Funding Source	Medicaid ☐	Provider One ID:		Non-Medicaid ☐	
DSM-5 diagnosis (ICD-10 code)		Is client PPW?	Yes ☐	No ☐	
Recommended ASAM LOC		Recommended length of care			

Supporting evidence for ASAM LOC and treatment duration

DIM	LOC	
Dim-1		
Dim-2		
Dim-3		
Dim-4		
Dim-5		
Dim-6		

Comments:

COMMCARE to complete below

Date and time of Authorization decision	Date:	Time:	
CommCare originated Authorization #			
Authorized ASAM LOC		Authorized Length of Service	
Date Authorization placed in "pending activation" status:			
Date and time individual is notified	Date:	Time:	
Signature of CommCare Rep:			

Authorization activation request to be completed by the admitting Residential SUD treatment provider

Name of agency requesting Authorization activation					
Name and title of individual requesting Authorization activation					
Requesting agency	Telephone #		Email contact		
First day of covered service		Last day of covered service			
Date and time of Authorization activation request	Date:	Time:			

COMMCARE to complete below

CommCare originated Authorization # verified	Yes		No	
Date and time of Authorization activation	Date:	Time:		
Signature of CommCare Rep:				