



**Highmark Blue Shield**  
**Behavioral Health Utilization Management**  
**Authorization Request Form**

**Submission Instructions: Only One Patient Per Fax. Please print all information.**  
**IMPORTANT! LIMIT FAXED INFORMATION TO JUST RELEVANT CLINICAL INFORMATION 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: 833-619-5745**

<b>Name of Requestor/Contact Person with Phone Number:</b>			
<b>Is this a request for an out of network gap exception?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Patient Name:</b>			
<b>Patient Date of Birth (mm/dd/yyyy):</b>			
<b>Patient ID/UMI Number (with Prefix):</b>			
<b>Name of Requestor/Contact Person:</b>			
<b>Requesting Provider Name:</b>			
<b>Requesting Provider NPI:</b>		<b>Requesting Provider BSID:</b>	
<b>Requesting Provider Address</b>		<b>Street:</b>	
		<b>City:</b>	
		<b>State:</b>	<b>Zip Code:</b>
<b>Requesting Provider Phone Number:</b>			
<b>Requesting Provider Fax Back Number:</b>			
<b>Primary Diagnosis Code(s):</b>			
<b>Inpatient Admission Date or Start of Care Date (mm/dd/yyyy):</b>			
<b>Type of review</b>		<input type="checkbox"/> <b>Precertification</b> <input type="checkbox"/> <b>Concurrent Review</b> <input type="checkbox"/> <b>Step Down</b>	
<b>Level of Care:</b>		<input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> Psychiatric Residential <input type="checkbox"/> Withdrawal Management <input type="checkbox"/> Residential-Rehab (Substance Use) <input type="checkbox"/> Outpatient:	
<b>OUTPATIENT ONLY Procedure Code(s):</b>			
<b>Admitting Facility Name:</b>			
<b>Admitting Facility NPI:</b>		<b>Facility BSID:</b>	
<b>Admitting Facility Address:</b>		<b>Street:</b>	
		<b>City:</b>	
		<b>State:</b>	<b>ZIP Code:</b>
<b>Admitting Facility Phone Number:</b>			
<b>Admitting Facility Fax Number:</b>			
<b>Servicing Physician/Provider Name:</b>			

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