

<b>Admission Type</b>	<input type="checkbox"/> Emergency Admit* <b>Date of Admit:</b>	<input type="checkbox"/> Elective Admit <b>Anticipated Date of Admit:</b>
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**\*For emergency admissions, if face sheet is attached, please put sponsor's Social Security number here: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_**

<b>Facility Type</b>	<input type="checkbox"/> Physical Health	<input type="checkbox"/> Acute Care Hospital	<input type="checkbox"/> Acute Rehab Facility/Unit	<input type="checkbox"/> Long Term Acute Care (LTAC)	<input type="checkbox"/> Skilled Nursing Facility (SNF)
	<input type="checkbox"/> Mental Health	<b>Psychiatric Inpatient Admissions</b> <input type="checkbox"/> Acute Psychiatric Emergency Admission <input type="checkbox"/> Elective Admission to a Residential Treatment Center (for children and adolescents) <input type="checkbox"/> Elective Psychiatric Admission for Eating Disorder	<b>Substance Use Disorder Inpatient Admissions</b> <input type="checkbox"/> Detox (not medical admission) <input type="checkbox"/> Substance Use Disorder Rehab	<b>Partial Hospitalization Program (PHP)</b> <input type="checkbox"/> Psychiatric (to include eating disorder PHP) <input type="checkbox"/> Full Day <input type="checkbox"/> Part Day <input type="checkbox"/> Substance use disorder rehab <input type="checkbox"/> Full Day <input type="checkbox"/> Part Day <b>Intensive Outpatient Program (IOP)</b> <input type="checkbox"/> Psychiatric (to include Eating Disorder) <input type="checkbox"/> Substance Use Disorder	<b>Services for Active Duty Service Members ONLY</b> <input type="checkbox"/> Inpatient PTSD Active Duty Program

### Patient Information

SPONSOR SSN/DoD Benefits Number:		Patient Date of Birth:	
Patient Last Name:		First Name:	Middle Initial:
Address:		City:	State: ZIP:
Home Phone:			
Other Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No		Policy #:	Carrier:

### Requesting Provider Information

Is the requesting provider performing the service?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provider Name:		Contact Name:	
Phone:	Fax:	NPI #:	Tax ID #:

### Servicing Provider Information

Provider Name:		Specialty:	
Phone:		Fax:	
Address:		City:	State: ZIP:

### Hospital/Health Care Facility Name (Required)

Name:	
Phone:	
Fax:	
Address:	
City:	State: ZIP:

### Requested Service: If additional codes are being requested, please attach additional sheets or use additional comments field below.

Diagnosis Code:	Description:		
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Diagnosis Code:	Description:		
CPT Code:	Description:	Units (BH):	Frequency (BH): /week
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**Please submit clinical information necessary to process this request. Additional comments:**