**ACT (Assertive Community Treatment) Admission template/requirements (submitted by provider)**

**Scenario:** Completing a pre-authorization review for the ACTLevel of Care (LOC)

**Effective Date:** 12/01/2015

Please Email (preferred) OR Fax the completed form to the contact information below:

EMAIL: [la.beh.auths@uhc.com](mailto:la.beh.auths@uhc.com%20)

FAX #: **1-855-202-7023**

***NOTE: Requests should be typed and not handwritten. An Assessment* *and LOCUS (Level of Care Utilization System) must be attached for all authorization requests.***

**REQUEST:**

* Provider name: Click here to enter text.
* Tax ID #: Click here to enter text.
* NPI #: Click here to enter text.
* Date and time of request: Click here to enter text.
* Member name: Click here to enter text.
* Member date of birth: Click here to enter text.
* Member Medicaid identification number: Click here to enter text.
* Name and phone number of the requestor: Click here to enter text.
* Diagnosis (includes Mental Health & Substance Use Disorders, Developmental Delay, personality, medical):

Click here to enter text.

* Current medication list: Click here to enter text.
* History of psychiatric-related inpatient stays and/or ER visits with dates of service: Click here to enter text.
* Current symptoms and how functioning is impacted: Click here to enter text.
* Legal issues (charges/probation/parole/incarceration) – with description: Click here to enter text.
* History of outpatient services (include… why is lower LOC not appropriate?): Click here to enter text.
* Living environment/residence: Click here to enter text.
* Risk factors (include history of violence, HI/SI, psychosis): Click here to enter text.
* Identified support systems: Click here to enter text.
* Current Primary Care Physician (list date of last visit): Click here to enter text.
* Treatment goals (behaviorally measurable) (include expected outcomes and timeframes):

Click here to enter text.

* Discharge plan: Click here to enter text.

***continued….***

**For additional days requested:**

* Identify specific Plan of Care (POC) (list goals met and remaining, include… why continue at this LOC?):

Click here to enter text.

* Support system development/involvement: Click here to enter text.
* Mental Status Exam/behavior/participation: Click here to enter text.
* Medication changes/compliance: Click here to enter text.
* Change in diagnosis: Click here to enter text.
* Specific discharge plan: Click here to enter text.
* Anticipated Length of Stay (LOS): Click here to enter text.
* Coordination of care activity: Click here to enter text.