

Applicable to: Behavioral Health (BH), Intellectual/Developmental Disabilities (I/DD), and/or Traumatic Brain Injury (TBI) services.
(Does not apply to I/DD Innovations Waiver.)

It is recommended to complete this form under the following circumstances:

- When a member is discharged from one of the following services:
 - Inpatient/Hospital
 - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)
 - Residential Levels 1 -4
 - Psychiatric Residential Treatment Facility (PRTF)
 - Diversion and Assessment Program (DAP)
 - Research Based Behavioral Health Treatment (RB-BHT)
- When an existing authorization needs to be end-dated or adjusted for any of the following reasons:
 - The member is transitioning to a new service, and no service authorization request will be submitted.
 - There is a termination of service due to member relocation, change in Medicaid eligibility, etc.
 - The member has chosen to withdraw from services.

INSTRUCTIONS: 1: Save the form to your desktop.
2: Complete the form.
3: Email the completed form to BHIDDManualAuthorizations@partnersbhm.org.

Note: Please complete this form in its entirety to ensure Partners has accurate information and timely communication if needed.

Questions? Contact UMQuestions@partnersbhm.org for assistance.

REQUEST DATE:	SERVICE CATEGORY: (Check one) ☐ BH ☐ I/DD ☐ TBI		
REQUESTING PROVIDER INFORMATION			
Requesting Provider Name:			
Name of Requesting Provider Contact Person:			Phone:
Email Address for Provider Contact Person:			
MEMBER DEMOGRAPHIC INFORMATION			
Member Name (First, M. I., Last):			
Member Date of Birth:	Partners Member ID:	Medicaid ID:	
Diagnosis Code:	Diagnosis Description/Name:		
AUTHORIZATION INFORMATION			
Authorization Number(s):	Service Code(s) and Name(s):	Authorization Start Date:	Discharge Date:

DISCHARGE REASON(s)			
TRANSITION PLAN(s)			