Behavioral Health Department
Alameda County Health

Fax Cover Sheet

Fax: 888.860.8068
Phone: 510-567-8141

Today's Date:	
Client Name:	DOB:
Hospital Name:	
UR point of contact:	Fax #:
Phone #:	Email:

☐ **Admit Auth Request:**
(up to 3 Acute days may be granted)
 	
Admission date: _____
 	
Documents required:
• Complete face sheet or Enrollment form
• Review Notes
  ○ Nursing Admission Note (including admission diagnosis) or Documentation of admission
	☐ **Continued Authorization Request:**
	# Days requested: _____ *
	(up to 5 Acute, up to 7 Admin days may be granted)
	
	Authorization Expires: _____
	
	Documents required:
	• Review Notes
	  ○ Documentation from day before authorization expires

☐ **Informal Expedited Reconsideration of a Denial or Modification with same MD while beneficiary is still hospitalized)** (Submit within 1 business day of written notification) First denied date of service(s):_____ Documents required: • Updated or additional information	☐ **Discharge:** Discharge date: _____ Documents required: • MD Discharge Summary • TAR
☐ **MD to MD / also referred to as Peer to Peer or Clinical Consultation** (Request anytime from admission until 1 business day after written notification of denial or modification issued **while beneficiary is still hospitalized)** Reason for consultation: Hospital MD name: Hospital MD email AND contact number: Provide preferred time Hospital MD may be reached: **Please let your Hospital MD know that an unknown or unfamiliar number may be calling during these times.* Documents required: • Updated or additional information	

**If a specific # of days is not provided, ACBHD UM will use clinical information to determine. See related instructions.*