Behavioral Health Department
Alameda County Health

Fax Cover Sheet

Fax: 888.860.8068 Phone: 510-567-8141

Today's Date:	Client Name:
Hospital Name:	SmartCare #:
UR Point of Contact:	Date of Birth:
Phone #:	**Admit Date:**

How to return determination: Fax #:
Email:

Please only check *one* area below: MD to MD, Reconsideration, Admittance, Continued, *or* Discharge

☐ **Admit Authorization Request:**	☐ **Cont. Authorization Request:**	☐ **Discharge:**
(up to 3 Acute days may be granted) Documents required: • Face sheet or complete Enrollment form • Documentation of admission to inpatient Unit	☐ 1 – 5 Acute **OR** ☐ 1 – 7 Admin days Documents required: • Clinical notes dated immediately after the last records sent	Discharge Date: _____ Documents required: ☐ MD Discharge Summary ☐ TAR (if applicable)

☐ **MD to MD / Peer to Peer or Clinical Consultation *while beneficiary is still hospitalized***
(Request must be submitted within 1 business day of written denial/modification)

- Hospital MD Name: _____
- Hospital MD email AND contact number: _____
- Date/Times Hospital MD can be reached: _____**
  (*times Must be between 8am – 5pm*)
- Is client still admitted? ☐ **Yes** ☐ **No**

Please let your Hospital MD know that an unknown or unfamiliar number may call during these times

☐ **Reconsideration of a Determination *while beneficiary is still hospitalized***
(Request must be submitted within 1 business day of written denial/modification)

☐ Denial
First denied date of service(s): _____
☐ Modification
Date of requested modified service(s): _____
Is client still admitted? ☐ **Yes** ☐ **No**
Documents required:

- ***Updated or additional information that was not previously submitted and demonstrating acuity***