Behavioral Health Department
Alameda County Health

Memorandum

Date: August 1, 2026

To: Acute Psychiatric Hospital Utilization Review Departments

From: Penny Bernhisel, LCSW, ACBHD Utilization Management Division Director

Subject: **REVISED Concurrent Review and Authorization Request Form for Hospital Services**

The purpose of this memo is to provide an overview of changes to ACBHD UM's **authorization request form.**

Background

Behavioral Health Information Notice (BHIN) 22-017 provides concurrent review standards and authorization requirements for inpatient psychiatric hospitals. Alameda County Behavioral Health Department previously issued an authorization request form for hospitals to submit authorization requests.

Revisions to Inpatient Authorization Request Form

Alameda County Behavioral Health Department has modified our Inpatient Authorization Requst form to improve readability and communication between hospital requestors and county UM . These changes align with BHIN 22-017 and include:

- A place to indicate "Admission Date" with every request
- A place to indicate the client's SmartCare # (if you know it)
    - This is the client's medical record number with Alameda County Behavioral Health
- Checkboxes for ease of completion
- Clarification of language for Reconsiderations in Denial or Modification determinations
- Information needed to complete MD to MD or Clinical Consultations

As a Reminder:

- Please include a specific number and type of days requested:
    - Admission requests: Up to 3 acute days
    - Continued/ongoing requests: Up to 5 acute days, up to 7 administrative days
- Decisions on concurrent authorization requests shall occur within 1 business day of receipt of a complete request
- Informal Expedited Appeal process within 1 business day of initial denial to allow for additional information/documentation to be considered
- Opportunities for clinical consultation including Peer Review (i.e. MD to MD) from the time of admission until 1 business day after a denial is issued

The Informal Expedited Appeal and Peer Review provide opportunities for plan of care agreements to be reached through real-time two-way dialogue. Our goal is to work in partnership to ensure timely decisions and care coordination.

Action Required

Please submit the Inpatient Authorization Request Form with each authorization request.

Share this information with your Utilization Review teams, as appropriate.

Support

This memo and the Inpatient Authorization Request form may be electornically accessed through: https://bhcsproviders.acgov.org/providers/UM/UM.htm

If you have any further questions please contact Alameda County Utilization Management (510) 567-8141 or UM@acgov.org.

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***