



An Anthem Company

<https://providers.amerigroup.com>

### Substance Use Disorder Inpatient Treatment Prior Authorization and Continued Care Request (for 3.2 WM, 3.5 and 3.7 levels of care)

To avoid delays in processing, please fill out this form completely and return it to Amerigroup Washington, Inc. by fax at 1-877-434-7578.

If you have any questions, please contact Provider Services at 1-800-454-3730.

<b>Member information</b>		
Name:		
Amerigroup ID number:	DOB:	
Address:		
City, State:	ZIP code:	
<b>Provider information</b>		
Facility name:	Status: <input type="checkbox"/> Participating <input type="checkbox"/> Nonparticipating	
NPI:	Admission status: <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary <input type="checkbox"/> Drug court client Next court date:	
TIN:		
Date of admission:		
Phone:		
Fax:		
UMR contact name:		
UMR phone:	UMR fax:	
Attending provider:		
Attending NPI:		
Level of care:	<input type="checkbox"/> 3.2 WM <input type="checkbox"/> 3.5 RTC <input type="checkbox"/> 3.7 RTC <input type="checkbox"/> Other:	
<b>Additional required documentation:</b>		
<ul style="list-style-type: none"> <li>• Current ASAM risk assessment</li> <li>• Current medication list or MAR</li> <li>• Current treatment plan with goal progress</li> <li>• Family meeting and group participation notes</li> <li>• Current discharge plan information</li> </ul>		
Number of days requested:	Estimated discharge date:	
Provider signature:		
Date:	Phone:	Fax:

Disclaimer: Authorization indicates that Amerigroup determined medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.