Reset Form

Notification of Substance Use Disorder (SUD) Outpatient Services

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form and allow 14 calendar days for decision.

Fax form and any relevant documentation to: **612-884-2033** or **1-855-260-9710**

For questions, call Mental Health and Substance Use Disorder Services at: **612-676-6533** or **1-833-276-1185**

Submit Request: UCare's Secure Email Site
Email: MHSUDservices@ucare.org

MEMBER INFORMATION

Member Name _____

UCare ID _____ PMI _____ DOB_____

Address, City, State, Zip _____

Phone _____ ICD-10 _____

SERVICE PROVIDER INFORMATION

Only for 1115 Waiver Providers: List the location in which the services are rendered and identify the UCare issued provider ID to ensure accurate rendering location is tied to concurrent authorization.

NPI Number _____ 1115 Waiver UCare Provider ID # _____
Do not use this section if you are not a Provider/Location approved under the 1115 Waiver

Facility Name _____

Location of Service Address _____

Location of Service Phone _____ Fax _____

Servicing Clinic/Location Name _____

Clinic/Location NPI _____

Provider Address, City, State, Zip _____

ADMINISTRATIVE INFORMATION

◯ Standard Request
Standard review timeframe for an authorization decision is within 14 calendar days or 10 business days from the date the request was received, as expeditiously as the member's health condition requires.

◯ Expedited Request
Expedited review timeframe for urgent/emergent requests is within 72 hours, as expeditiously as the member's health condition requires. **Only request an expedited review if waiting the standard review timeframe would potentially jeopardize the member's health, life or ability to regain maximum function.** ***Billing and retro authorizations are not expedited.***

Request Sent By _____ Phone _____

Requestor email (if different from above): _____

Notification of SUD Outpatient Services

DATES/CODES/UNITS

SERVICE REQUESTED	Start Date	End Date

Please list all necessary code(s) and units/visits request each code.

Billing Code Select an Option _____ Units Requested _____

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Billing Code Select an Option _____ Units Requested _____

Attach applicable documentation:

☐ Rule 25 Assessment ☐ Rule 25 Summary dated within 45 days of request for services

☐ Comprehensive Assessment ☐ Progress Notes ☐ Discharge Summary

ADDITIONAL INFORMATION TO SUPPORT REVIEW