Administrative Days Authorization Request Form

Visit the provider portal to submit initial authorization requests online at https://countycare.valence.care

Fax completed form to
Medical:1-800-856-9434
BH/SUD: 1-800-498-8217
Phone number: 1-855-444-1661
*** = Required Information**

REQUESTS SHOULD BE PROVIDED WITHIN 2 BUSINESS DAYS FROM DATE OF ADVERSE DETERMINATION. RETRO REQUESTS WILL BE CONSIDERED BUT MUST CONTAIN CLEAR DOCUMENTATION OF SUBSTANTIAL DISCHARGE BARRIERS TO BE CONSIDERED.

***Requestor's Contact Name:** ***Requestor's Contact Number:**

PATIENT INFORMATION	
*Member Name:	*Date of Birth:
*Member ID Number:	Member Phone Number:
SERVICE TYPE	
☐ Inpatient Mental Health/Detox	☐ Inpatient Medical
PROCEDURE INFORMATION	
***ICD-10** Diagnosis:	Diagnosis Description:
*CPT Code:_____ Units: _____	*Requested Start Date: _____
PROVIDER INFORMATION	
Ordering Provider: ☐ *Primary Care Physician*	
*Name: _____	*NPI: _____ TIN: _____
*Fax: _____	Phone _____
*Address:	
Servicing Provider: ☐ *Same as Ordering*	
*Name: _____	*NPI: _____ *TIN: _____
*Fax: _____	Phone _____
*Address:	
Facility: ☐ *N/A*	
*Name: _____	*NPI: _____ *TIN: _____
*Fax: _____	Phone _____
*Address:	

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED & RETURNED.

OPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED.

LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION

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CARE COORDINATION

UR Department	Discharge Planner	Health Plan Care Coordinator
☐ N/A	☐ N/A	☐ N/A
Name:	Name:	Name:
Phone:	Phone:	Phone:
Fax:	Fax:	Fax:
Email:	Email:	Email:

REASON THE MEMBER CANNOT RETURN TO THEIR PREVIOUS PLACEMENT

CLINICAL INFORMATION

Please provide a summary of daily discharge planning activities, barriers to transition and efforts to overcome these, including names and dates of facilities or providers the case has been referred to and the outcomes of those referrals, patient/family decisions around discharge planning options, and any other circumstances around discharge planning. Additional information may be needed in ordered to process your request. If we are unable to obtain additional information, it will impact processing. Please do NOT attach clinical. Provide summary below.

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