



Administrative Days Authorization Request Form

Visit the provider portal to submit initial authorization requests online at <https://countycare.valencehealth.com/Login>

Fax completed form to
 Medical: 1-800-854-9434
 BH/SUD: 1-800-498-8217
 Phone number: 1-855-444-1661
*** = Required Information**

REQUEST MUST BE COMPLETED WITHIN 2 BUSINESS DAYS FROM LAST APPROVED DAY FOR ADMINISTRATIVE DAYS 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	
<input type="checkbox"/> Inpatient Mental Health/Detox	<input type="checkbox"/> Inpatient Medical
PROCEDURE INFORMATION	
*ICD-10 Diagnosis:	Diagnosis Description:
*CPT Code: _____ Units: _____	*Requested Start Date: _____
PROVIDER INFORMATION	
Ordering Provider:	<input type="checkbox"/> Primary Care Physician
*Name: _____	*NPI: _____ TIN: _____
*Fax: _____	Phone _____
*Address: _____	
Servicing Provider:	<input type="checkbox"/> Same as Ordering
*Name: _____	*NPI: _____ *TIN: _____
*Fax: _____	Phone _____
*Address: _____	
Facility:	<input type="checkbox"/> N/A
*Name: _____	*NPI: _____ *TIN: _____
*Fax: _____	Phone _____
*Address: _____	

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED & RETURNED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED.
LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.



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CARE COORDINATION		
UR Department	Discharge Planner	Health Plan Care Coordinator
<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	<input type="checkbox"/> 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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