



VERMONT MEDICAID ADMISSION NOTIFICATION FORM

For

Inpatient Psychiatric Services

The following information and justification must be provided to the Department of Vermont Health Access (DVHA) (**toll-free fax: 855-275-1212**) within 24 hours or next business day of an urgent or emergent hospital admission. All elective (planned) admissions will require notification prior to admission for authorization. The Utilization Reviewer will contact the facility after notification is received by the DVHA to begin the authorization process.

There will be no authorization unless the following information is provided in full to DVHA

Date of Admission: _____ Admission Diagnosis: _____

Patient Last Name: _____ First Name: _____

Medicaid ID Number: _____ Date of Birth: _____

Physical Address _____

Does the patient have a guardian (DCF, or Public Guardian)? Y N (circle one)

If yes, guardian's name: _____

Is patient receiving mental health services in Vermont from a Community Mental Health Center (CMHC)? Y N (circle one) If yes, name of agency _____

If the answer to the previous question is "No", is the patient receiving other mental health services in Vermont? Y N (circle one) If yes, name of provider _____

Referral Source (if applicable) _____

Facility Name _____ VT Medicaid Provider Number _____

Contact Person for Authorizations _____ Phone # _____

Anticipated Discharge Date _____

Please attach the admissions assessment to include justification for psychiatric inpatient admission, diagnoses and medications

For inpatient detoxification admissions please include the date the patient began scoring for the detox protocol medication taper (ie. suboxone, subutex, methadone, librium)