

**VT Medicaid Admission Notification Form for**

**Inpatient Psychiatric & Detoxification 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 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: Click to enter a date. Unit admitted to: Click to enter text.

Admission diagnosis (ICD-10 code):­­­ Click to enter text.

Patient Last Name: Click to enter text. First Name: Click to enter text.

Medicaid ID Number: Click to enter text. Date of Birth: Click to enter a date.

Physical Address: Click to enter text. Gender:

County: Click to enter text. Phone number: Click to enter text.

**Is the patient being admitted involuntarily?**  Yes  No

Does the patient have Medicare?  Yes  No Other insurance coverage?  Yes  No

If yes to either, enter the # of days covered or unknown. Click to enter text.

Is the patient homeless upon admission?  Yes  No

Is the patient pregnant?  Yes  No

Does the patient have a guardian (DCF, or Public Guardian)?  Yes  No

If “Yes”, guardian’s name: Click to enter text.

Is the patient receiving mental health services in Vermont from a Community Mental Health Center (CMHC)?

Yes  No If yes, name of agency: Click to enter text.

If the answer to the previous question is “No”, is the patient receiving other mental health services in Vermont?

Yes  No If “Yes”, name of provider: Click to enter text.

Referral Source (if applicable): Click to enter text.

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Facility Name: Click to enter text. VT Medicaid Provider Number: Click to enter text.

Contact Person for Authorizations: Click to enter text.

Phone #: Click to enter text. Return Fax #: Click to enter text.

Anticipated Discharge Date: Click to enter a date.

Anticipated Discharge Referral to a CMHC?  Yes  No

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