

**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 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit admitted to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Admission diagnosis (ICD-10 code):­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

[ ]  Yes [ ]  No If yes, name of agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VT Medicaid Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person for Authorizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anticipated Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anticipated Discharge Referral to a CMHC? [ ]  Yes [ ]  No

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

Updated 01/01/22