

**VT Medicaid Request for Per Diem Rate for Mental Health**

**Extended Stays in Emergency Departments**

The following information must be provided to the Department of Vermont Health Access (DVHA) (**toll-free fax 855-275-1212**). The Utilization Reviewer will contact the facility within 3 business days via fax with authorization decisions after notification is received and reviewed by the DVHA.

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

Date of Admission to ED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of Admission to ED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the member homeless upon admission?  Yes  No

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

If member has Medicare, have Medicare days been exhausted?  Yes  No

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

If “Yes,” guardian’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the member 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 member receiving other mental health services in Vermont?

Yes  No If “Yes,” name of provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requesting Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VT Medicaid Provider Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Anticipated Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of days being requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List of inpatient psychiatric facilities where referrals have been made AND status of those referrals:**

Please submit this form with attached supporting clinical documentation (crisis screening, MD, RN, SW notes)\_\_\_\_\_\_\_\_\_

Updated 6/29/22