

**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 DVHA**

Date of Admission to ED Click to enter a date. Time of Admission to ED: Click to enter text.

Member 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. Gender: Click to enter text.

Address: Click to enter text. County: Click to enter text.

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: 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.

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Requesting 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. Number of days being requested: Click to enter text.

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

Click to enter text.

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

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