

**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 requesting hospital 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: \_\_\_\_\_\_\_\_\_

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

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

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

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

Was the member homeless upon admission?  Yes  No

Was the member admitted involuntarily**?**  Yes  No

If member had Medicare, were Medicare days exhausted during the ED stay?  Yes  No

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

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

Was 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 was “No,” was the member receiving other mental health services in Vermont?

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

Requesting Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_VT Medicaid Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Please submit this form with attached supporting clinical documentation (crisis screening, MD, RN, SW notes, all referrals made with dates and statuses)

Updated 12/07/22