Behavioral Health
Admission Notification Form

PacificSource HEALTH PLANS

Instructions:

1. Please complete all fields on the form. Missing information will delay the notification process.
2. **Notification form** and **admission documentation are required within 48 hours of admit.**
3. A facility license is **required** for all out-of-network facilities.

If you have any questions, please contact the Health Services team toll-free at **888-691-8209,** TTY: 711. We accept all relay calls.

Participating providers please submit online through InTouch. Go to PacificSource.com/providers/about-intouch-providers for information.

1. Patient

First name _____ Last name _____

Date of birth _____ Member ID number _____

2. Services

Type of service

☐ Inpatient ☐ Inpatient withdrawal management ☐ Residential treatment ☐ Partial hospitalization/day treatment

ICD 10 diagnosis code and description (required) _____

Admission date _____ Estimated length of stay (days) _____

Retrospective review? ☐ Yes ☐ No Dates of service _____

3. Provider contact information

Contact person:

Name _____ Date _____

Phone _____ Extension _____ Fax _____

Attending/treating practitioner:

Name _____ Date _____

Phone _____ Extension _____ Fax _____

Address _____

City _____ State _____ ZIP _____

TIN _____ NPI _____

Facility/place of service:

Name _____ Date _____

Phone _____ Extension _____ Fax _____

Address _____

City _____ State _____ ZIP _____

TIN _____ NPI _____

Please return to:

PacificSource Health Plans, ATTN: Health Services Dept., PO Box 7068, Springfield, OR 97475-0068 | Fax: 541-225-3667