Behavioral Health Admission Notification Form

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 at **(541) 684-5584** or toll-free at **(888) 691-8209.**

Participating providers submit online through InTouch. Go to **PacificSource.com/aboutproviderintouch** for information.

1. Patient

First name ______________________ Last name ______________________

Date of birth ______________________ Member ID number ______________________

2. Services

Type of service ______________________

ICD 10 diagnosis code and description (required) ______________________

Inpatient 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., 110 International Way, Springfield, OR 97477 | Fax: (541) 225-3667