PRIOR AUTHORIZATION INITIAL BEHAVIORAL HEALTH CONTACT AND TRIAGE REQUEST

PERSON COMPLETING AND SUBMITTING THIS FORM:

Name:		Facility:
Phone:	Fax:	Date form Submitted:

MEMBER INFORMATION:

Member Name:	DOB:	Member ID:
State ID:	SSN:	
Member address:		
City:	State:	Zip:
Member Phone:		

Select the line of business or organization this request is for (*check all that apply*):

☐ Colorado Access Advantage
☐ CHP+ offered by Colorado Access
☐ CAMC
☐ Access Behavioral Care Denver
☐ CHP+ State Managed Care Network
☐ CAPE
☐ Access Behavioral Care NE
☐ Access Health Colorado

SERVICES:

☐ Routine Outpatient Treatement - no authorization required if member is eligible and provider is contracted with Colorado Access (must offer appointment within seven business days)

☐ **Urgent** (must see member within 24 hours)
Requested Appointment Date: Time:

Requested Appointment Date: Time:

Please explain any delay in meeting the required timeframes:

For routine or urgent care, you must offer a referral to us if you cannot meet the required timeframes for access to services.
Referral offered? ☐ Yes ☐No If "No," please explain why:

☐ **Emergent** (must see member within one hour urban/suburban; two hours in rural areas)

Date/time request for MH evaluation was made: Date/time MH evaluation was initiated:

Was the patient evaluated within one hour of arrival at ED? ☐ Yes ☐ No
Time frame between request for MH evaluation and time MH evaluation initiated?
☐ <1 hour ☐ 1-2 hours ☐ 2-4 hours ☐ >4 hours
Please explain any delay in meeting the required timeframes:

☐ **Inpatient Treatment** - Facility/Provider:

☐ **ATU** - Facility/Provider:

☐ **Day Treatment** - Facility/Provider:

☐ **Short Term Residential** - Facility/Provider:

☐ **Respite** - Facility/Provider:

☐ **Other** - Facility/Provider:

After completing this form, fax it to (720) 744-5130 or 877-232-5976
Monday -Friday 5 a.m.-8 p.m. and 24 hours on Saturday and Sunday
After-hours fax number 303-361-8258

coaccess.com
1-800-511-5010

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