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|  | Behavioral Health Administration  **Personal Service Request / Standard Referral** |
| 1. Facility Name:   Campus: | |
| 1. Patient / Resident Name: | |
| 1. Medical Record Number: | |
| 1. Sex: | |
| 1. Date of Birth: | |
| 1. Psychiatric Provider: | |
| 1. Medical Provider: | |
| 1. Vendor Name: | |
| 1. Address: | |
| 1. Phone Number: | |
| 1. What service is required: | |
| 1. Preauthorization Required by Contract?  Yes  No | |
| **Note to Vendor: Behavioral Health Administration facilities reimburse at the Medicaid rate or contracted vendor rate. Send billing to consolidated business services in care of the patient / resident.\*** | |
| 1. Insurance Information: | |
| 1. Primary Health Plan: | |
| 1. ID Number: | |
| 1. Secondary Coverage: | |
| 1. ID Number: | |
| **Other Insurance Information: If patient / resident has insurance, please bill insurance as first payer and Behavioral Health Administration as secondary payer. Send billing for co-insurance and deductibles to facility in care of the patient / resident.** | |
| **All technical component chares are the responsibility of Behavioral Health Administration facilities and will be paid at the Medicaid rate or contracted vendor rate.** | |
| Contact: [cbs3institution-fiscal@dshs.wa.gov](mailto:cbs3institution-fiscal@dshs.wa.gov) or (360) 764-0431  Consolidated Business Services 3  1949 South State Street  Tacoma WA 98405 | |
| \* Please note: Behavioral Health Administration facilities shall not pay any claims for services submitted more than 12 months after the calendar month in which the services were performed. | |
| **Instructions**   1. Facility Name: Select facility that patient / resident is in residence. Add campus name if the facility has multiple campuses. 2. Patient / Resident Name: Name of patient / resident. 3. Medical Record Number: Facility Medical Record Number located in the electronic health record. 4. Sex: Gender or Preferred Gender. 5. Date of Birth: Patient / Resident’s date of birth. 6. Psychiatric Provider: Name of Facility Psychiatrist Assigned. 7. Medical Provider: Name of Facility Medical Provider Assigned. 8. Vendor Name: Name of Facility Patient / Resident referred. 9. Address: Address of Vendor. 10. Phone Number: Phone Number of Vendor. 11. What Service is Required: Reason for referral to outside medical provider. 12. Preauthorization Required by MOU: If service is outside of preapproved listed in contract, preauthorization from attending physician is required, reference Medical Preauthorization form, DSHS13-949. 13. Insurance Information: Name of Patient / Resident Insurance if no insurance please add name of facility. 14. Primary Health Plan: Name of Health Plan, if no insurance please write “None.” 15. ID Number: Health Plan Number of insurance, if no insurance please add Patient / Resident Medical Record Number. 16. Secondary Coverage: Name of Patient / Resident secondary insurance if no secondary insurance, please write “None.” 17. ID Number: Health Plan Number of secondary insurance, if no secondary insurance please write “None.” | |