

## BANNER UNIVERSITY HEALTH PLAN CERTIFICATION OF NEED (CON)

- 1) A CON must be completed prior to or at the time of a non-emergent admission.
- 2) A CON must be completed within 72 hours of an emergency admission for members age 21 and older and within 14 days of admission for members under the age of 21 years.
- 3) A CON must be completed if a member applies for Medicaid Assistance while in the hospital, before Medicaid funding is authorized.

DATE AND TIME OF CON:		□a.m. □p.m.		
Type of Service Requested: ☐ Hospital ☐ Behavioral Health Inpatient Facility R				
MEMBER INFORMATION				
Name:		Date of Birth:		
Street Address:		City:	Zip Code:	
AHCCCS ID:				
Outpatient Provider:		Phone Number:		
Current DSM Diagnoses & Codes:				
Current Medical Diagnoses/Conditions:				
☐ Court Ordered Evaluation ☐ Court Or	dered Treatment	□Voluntary		
<ul> <li>Please indicate why proper treatment inpatient basis under the direction of a</li> </ul>	•	havioral health condition	on requires services on a hospital or	
<ul> <li>Please indicate why the requested ser- prevent further regression so this level of</li> </ul>		•	ve the person's condition or	
Please indicate why outpatient resource person.	ces available in the	e community do not me	et the treatment needs of this	
Proposed Facility:				
Requested Service Dates: From:	To:	Discha	rge:	
Facility UM Contact:		Phone #:		
I am aware of the member's condition a is appropriate.	and have been pro	vided sufficient informa	ation to determine this level of care	
Physician's Signature:	Prin	ıt Name	Date:	