Banner University Health Plans
Banner – University Family Care

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/ IMD ☐ Hospital/ Non IMD send via fax to (520) 874-3420
☐ Behavioral Health Inpatient Facility Residential Services (BHIF-RTC) send via fax to (520) 694-0599

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 Ordered Treatment ☐Voluntary

▪ Please indicate why proper treatment of the person's behavioral health condition requires services on a hospital or inpatient basis under the direction of a physician.

_____
_____
_____

▪ Please indicate why the requested service can reasonably be expected to improve the person's condition or prevent further regression so this level of service will no longer be needed.

_____
_____
_____

▪ Please indicate why outpatient resources available in the community do not meet the treatment needs of this person.

_____
_____
_____

Proposed Facility:_____Requested Admission Date: _____

Requested Service Dates: From:_____To:_____Discharge:_____

Facility UM Contact:_____Phone #: _____

I am aware of the member's condition and have been provided sufficient information to determine this level of care is appropriate.

Physician's Signature:_____Print Name:_____Date:_____