Banner University Health Plans

Out of Home Notification Form

This form is sent to the Health Plan within 2 business days when a member is admitted to a behavioral health out of home facility or home. This includes child BHIF, child and adult BHRF and child and adult HCTC.

Send by Fax to:
520-694-0599

Member Name: _____Age: ___DOB: _____Gender: _____

AHCCCS ID: _____

Date of Admission: _____Expected Discharge Date: _____

Name of Facility: _____

Address of Facility: _____

Contact Name: _____Phone number: _____

Email Address: _____Fax number: _____

Name of CFT/ART Facilitator: _____

Outpatient Agency: _____Phone number: _____

Email Address: _____

If applicable – Name of Member's parent/guardian: _____

Failure to submit required clinical documents as per Provider Checklist BUFC may issue a denial of payment.