Banner University Health Plans
Banner – University Family Care

BANNER UNIVERSITY HEALTH PLAN
RE-CERTIFICATION OF NEED (RON)

1) For persons 21 years of age or older, a RON must be completed every 60 days.
2) For persons age 20 years or younger, the treatment plan must be completed and reviewed every 30 days. The completion and review of the treatment plan meets the requirement for the recertification of need.

DATE AND TIME OF RON:________________@___________☐a.m. ☐p.m.

Type of Service Requested: ☐ Hospital/ IMD ☐ Hospital/ Non IMD
☐ Behavioral Health Inpatient Facility Residential Services (BHIF-RTC)

MEMBER INFORMATION

Name:____Date of Birth: _______________________

Street Address:____________________________________City:________________Zip Code:___________

AHCCCS ID: _________________________________

Outpatient Provider:_______________________________________Phone Number:__________________

Current DSM - 5/ICD 10 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 continues to require 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.

____

____

FACILITY INFORMATION:

Facility Name:______________________________________Date of Admission: ______________________

Facility Phone #:____________________Facility Contact: ____________________________________

Requested Service Dates: From:________________To: __________________

Discharge Date: ________________

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

Behavioral Health Medical Professional's Signature:____________________Print Name:_____________ Date:________

For Banner Complete Care members send via fax to: BUHP PA (520) 874-3411