

## Out of Home Admission Notification

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:  
520-874-3411

Member Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

AHCCCS ID: \_\_\_\_\_ Level of Care: BHIF , BHRF , TFC (children) , ABHTH

Date of Admission: \_\_\_\_\_ Expected Discharge Date: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

NPI Number of Facility: \_\_\_\_\_

Facility Contact Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Email Address: \_\_\_\_\_ Fax number: \_\_\_\_\_

Name of CFT/ART Facilitator/Case Manager: \_\_\_\_\_

Outpatient Agency: \_\_\_\_\_ Phone number: \_\_\_\_\_

Email Address: \_\_\_\_\_

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