

## 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) Send via fax to BUHP PA (520) 874-3411 MEMBER INFORMATION 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:\_\_\_\_\_

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:\_\_\_\_

Discharge Date: