PLEASE SEND FORM TO ACTIVE HEATLH MANAGEMENT AT:
* Fax: (866) 617.4900, or
* Upload in Pre-Certification portal: https://precertification.activehealth.com/

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

ADMISSION NOTIFICATION FORM

For use by inpatient and partial hospitalization to notify insurers within two business days of covered patient admission.

Patient Name:	Date of Birth:
Legal Guardian (and phone number) if under 18:	Insurance Plan Name and ID:
Admitting Program Name:	Date of Admission:
Service Location/Billing Address	NPI and/or TIN:

Diagnoses

Psychiatric:	Co-occurring SUD:	Medical:
		☐ NO ☐YES (list):
	☐Tobacco (or other nicotine) Use Disorder	

Reason for Admission:

Recommended Trigger(s) for utilization management (check one or more, if any):
☐ Current AOT order or AOT order expired in last 5 years
☐ Three or more inpatient psychiatric admissions in last year
☐ Four or more psychiatric emergency department or CPEP visits in last year
☐ Three or more medical or surgical hospital inpatient admissions in last year
☐ Psychiatric inpatient readmission within 30 days of psychiatric inpatient discharge
☐ Other _____

Clinician Contact Information:	Administrative Contact Information:

Clinician Signature	Print Name and Title	Date