



MEDICAL MUTUAL®

Inpatient Behavioral Health Fax Form

***** Please note when submitting this form, include Clinical information. *****

*****Please note if you are submitting a Residential Case to also please attach the License/Accreditation for your Facility***
Please fax to: 1 800 524 9817**

(Check All That Apply)

BH Admission Continued Stay Discharge Substance Abuse/Rehab Detox Residential

Case # (If applicable): # _____

Facility Name: _____

Facility Tax ID# _____ Facility NPI# _____

Facility Servicing Address: _____ City: _____ State: _____ Zip: _____

Attending/Admitting Physician Name: _____ NPI #: _____

Physician address same as facility? Yes No

If "No" state full address _____

Date of Admit: _____ Date of Discharge (if applicable): _____

- Inpatient Elective Procedure Code is required: CPT Code(s) _____

Diagnosis Codes: _____ - _____

Contact Information: _____

Fax Back #: _____ Phone #: _____

Member Name: _____

Policy/Member ID#: _____ D.O.B: ____ / ____ / ____

Additional Information:

CONFIDENTIALITY NOTICE

This message is intended only for the use of the individual of entity to which it is addressed and may contain information that is privileged, confidential or exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are hereby notified that you are strictly prohibited from reading, disseminating, copying or distributing this communication. If you have received this communication in error, please notify us immediately at 800.338.4114 and return the original message to us via U.S. mail at the address below. Thank you.

Care Management Department
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