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:

Care Management Department
2060 E. 9th Street
Cleveland, OH 44115-1355
Phone Number: 1-800-338-4114