Beaver County Behavioral Health
Authorization Request

041-_____

Provider: **Smith's PCH RESPITE** Provider #: **1143** Provider ID: **673082** Date: _____

Consumer Name: _____ DOB: _____ Race/Ethnicity: _____

Address: _____ Phone#: _____ Gender: □ M □ F

Discharge Address: _____ Phone#: _____

Type of Authorization: □ Admission □ Discharge (Please use address individual is being discharged to)

Name of Program and Type of Service

Begin Date	End Date	# of units requested	Program Name	Facility	Svc Class	POS	Base Svc Code	Mod
			Smith's PCH	**314**	**RSP**	**99**	**H0045**	

Reason for respite request: _____

Comments (if applicable): _____

Note: Any changes in name, county of residence, and insurance need to be reported to BCBH immediately

***ICD 10 Diagnosis Code:** _____ ***Diagnosis Description:** _____
*To authorize services, an ICD-10 Diagnosis code and Description is needed.

Name of SPA / Case Manager: (print) _____ Signature _____

Name of Smith's PCH staff approving respite admission: (print) _____ Signature _____

Name of BCBH Administration staff approving respite: (print) _____

SPA is responsible to complete this form and send via e-mail to: jwallace@bcbh.org