Mental Health Treatment Notification of Admission

This Notification of Admission should be completed by Inpatient Hospitals and Facilities, and Residential Treatment Centers to notify MVP Health Care® of an MVP member being admitted for mental health treatment. Provide all required information and submit the completed form and supporting clinical documentation (admission assessment(s), psychosocial evaluation, treatment information, medical notes, etc.). If services are being rendered in an out-of-network hospital or facility, and the member does not have out-of-network benefits, include the rationale for out-of-network services.

Page 2, Notification of Admission Support Documentation, may be completed in lieu of providing supporting documents.

Submit this completed and signed request to MVP within *two business days* by email to bhservices@mvphealthcare.com or fax to 1-855-853-4850.

Section 1: Patient/Member Information

Member Name	Date of Birth	MVP Member ID No.	Phone No.

Street Address *Apt. No.*	City	State	Zip Code

Section 2: Provider Information

Admitting Hospital/Facility Name	NPI No.	Tax ID No.

Admitting Hospital/Facility Street Address	City	State	Zip Code

Billing Street Address	City	State	Zip Code

Utilization Review Contact Name	Phone No.	Fax No.

Case Manager Name	Phone No.	Fax No.

Section 3: Clinical Information

Date of Admission	Is this Request for Out-of-Network Services ☐ **Yes** ☐ **No**

Needs Requiring Specialty Focus ☐ *Not Applicable*

Mental Health Diagnoses

Substance Use Disorder Diagnoses ☐ None ☐ Tobacco or Other Nicotine Use Disorder

Provide the Actual Substance Use Disorder Diagnoses if neither option apply.

Medical Diagnoses ☐ None ☐ Other *(explain below)*

The completed form must be signed and dated on page 2 before it is submitted.

Member Name	*Date of Birth*	*MVP Member ID No.*

Mental Health Treatment Admission Supporting Information

The following information may be provided in lieu of including supporting documents with this Notification of Admission.

Medical Necessity Information

Chief Complaint and Reason for Admission

Out-of-Network Rationale *(if indicated)*

Medical and/or Substance Use Disorder Problems in Need of Stabilization ☐ Not Applicable

Medications *(including route, dosage, and frequency)*

Initial Treatment Plan

Therapies *(select all that apply and provide below an explanation of the therapies)*

☐ Individual ☐ Group ☐ Family ☐ Coping Skills ☐ Social Skills ☐ Psychoeducation

Medications Changes

Coordination of Care with Other Providers *(provide below an explanation of the coordination of care with other providers)*

☐ PCP Notified of Admission ☐ PCP Not Notified of Admission

Barriers to Discharge

Discharge Plan

Disposition *(select one)*

☐ Home Alone ☐ Home with Supports ☐ Shelter ☐ Supportive Housing ☐ Other *(explain below)*

Aftercare Plan *(select one)*

☐ Inpatient ☐ Residential ☐ Partial Hospital ☐ Intensive Outpatient ☐ Outpatient ☐ Other *(explain below)*

Name of Person Completing this form (print)	*Signature*	*Date*