



Residential Treatment Admission (RTC) Notification Form

Please complete all information requested on this form. Fax to 1-866-535-6974.

Member Name _____ Member Phone _____

Member DOB _____ Member ID# _____

Member Address *Street* _____ *Apt/Unit#* _____

City _____ *State* _____ *Zip* _____

Parent/Guardian Name _____ Phone for Member/Parent/Guardian _____

Facility Name _____

Facility Contact Name _____ Facility Contact Phone _____

Emergency/Other Contact _____ Facility Fax Number _____

Outpatient Therapist _____ Outpatient Therapist Phone _____

Psychiatrist _____ Psychiatrist Phone _____

Case Manager *(if applicable)* _____ Case Manager Phone _____

Current ICD Diagnosis

Primary _____ Secondary _____

Tertiary _____ Additional _____

Current Medications _____

Discharge Plan _____

Admission Date _____ Estimated Length of Stay _____

SUBMIT TO: Utilization Management Department
Fax: 1-866-535-6974

MHS Health is committed to our members care. Please contact our Case Management department for any discharge planning needs at 1-888-713-6180.