

**ACT CONTINUED STAY REVIEW AUTHORIZATION REQUEST FORM  
(ACT – CSR)**

<b>To be Completed by OBH</b>					<i>Revised 2.16.16</i>
<b>Tracking #</b>		<b>Date/Time of Receipt</b>			
<b>PROVIDER INFORMATION</b>					
<b>Provider Company Name</b>					
<b>Person Making Referral</b>		<b>Credentials</b>			
<b>Provider Phone #</b>		<b>Provider Fax #</b>			
<b>Date of Request</b>		<b>Provider Email</b>			
<b>Provider Address</b>					
<b>CLIENT INFORMATION</b>					
<b>Recipient Name</b>					<b>SS#</b>
<b>Age</b>		<b>DOB</b>		<b>Ethnicity</b>	
<b>Gender</b>		<b>Gender Expression</b>		<b>Marital Status</b>	
<b>Parent/Guardian</b>					<b>Phone #</b>
<b>Address</b>					
<b>ACT CONTINUED STAY REVIEW REQUEST</b>					
<b>Admit Date</b>		<b>Last Date Authorized by OBH</b>			
<b>Requested Start Date</b>		<b>Requested End Date</b>			
<b>Diagnosis (any changes or additions)</b>					
<b>ICD10 Code</b>					
<b>Medications</b>					
<b>Changes to Current Medications</b>					
<b>PRNs</b>					
<b>REASON FOR EXTENDED AUTHORIZATION</b>					
<b>Detailed reason why continued stay is necessary</b>					
<b>Comment</b>					
<b>Detail the discharge plan as well as day of anticipated discharge. Identify outpatient provider and recommended services, living arrangements.</b>					
<b>Comment</b>					