Washington State Department of Social & Health Services
Transforming lives

Behavioral Health Administration

Personal Service Request / Standard Referral

1. Facility Name: **Please choose an item.** Campus:
2. Patient / Resident Name:
3. Medical Record Number:
4. Sex:
5. Date of Birth:
6. Psychiatric Provider:
7. Medical Provider:
8. Vendor Name:
9. Address:
10. Phone Number:
11. What service is required:
12. Preauthorization Required by Contract? ☐ Yes ☐ No
Note to Vendor: Behavioral Health Administration facilities reimburse at the Medicaid rate or contracted vendor rate. Send billing to consolidated business services in care of the patient / resident.*
13. Insurance Information:
14. Primary Health Plan:
15. ID Number:
16. Secondary Coverage:
17. ID Number:
Other Insurance Information: If patient / resident has insurance, please bill insurance as first payer and Behavioral Health Administration as secondary payer. Send billing for co-insurance and deductibles to facility in care of the patient / resident.
All technical component chares are the responsibility of Behavioral Health Administration facilities and will be paid at the Medicaid rate or contracted vendor rate.

Contact: cbs3institution-fiscal@dshs.wa.gov or (360) 764-0431
Consolidated Business Services 3
1949 South State Street
Tacoma WA 98405

* Please note: Behavioral Health Administration facilities shall not pay any claims for services submitted more than 12 months after the calendar month in which the services were performed.

Instructions

1. Facility Name: Select facility that patient / resident is in residence. Add campus name if at a facility that has multiple campuses.
2. Patient / Resident Name: Name of patient / resident.
3. Medical Record Number: Facility Medical Record Number located in Wellsky.
4. Sex: Gender or Preferred Gender.
5. Date of Birth: Patient / Resident's date of birth.
6. Psychiatric Provider: Name of Facility Psychiatrist Assigned.
7. Medical Provider: Name of Facility Medical Provider Assigned.
8. Vendor Name: Name of Facility Patient / Resident referred.
9. Address: Address of Vendor.
10. Phone Number: Phone Number of Vendor.
11. What Service is Required: Reason for referral to outside medical provider.
12. Preauthorization Required by MOU: I f service is outside of preapproved listed in contract, preauthorization from attending physician is required, reference RTF Medical Preauthorization form, DSHS13-494.
13. Insurance Information: Name of Patient / Resident Insurance if no insurance please add name of facility.
14. Primary Health Plan: Name of Health Plan if no insurance please write “None.”
15. ID Number: Health Plan Number of insurance if no insurance please add Patient / Resident Medical Record Number.
16. Secondary Coverage: Name of Patient / Resident secondary insurance if no secondary insurance, please write “None.”
17. ID Number: Health Plan Number of secondary insurance if no secondary insurance please write “None.”