Banner Health Plans

BANNER HEALTH PLANS
CERTIFICATION OF NEED (CON)

1) A CON must be completed prior to or at the time of a non-emergent admission.
2) A CON must be completed within 72 hours of an emergency admission for members age 21 and older and within 14 days of admission for members under the age of 21 years.
3) A CON must be completed if a member applies for Medicaid Assistance while in the hospital before Medicaid funding is authorized.

DATE AND TIME OF CON:__________________@____________☐a.m. ☐p.m.

Type of Service Requested:

☐ Hospital/ IMD ☐ Hospital/ Non IMD
Send via Fax to **(520) 874-3420**

☐ **BHIF – RTC** - **B**ehavioral **H**ealth **I**npatient **F**acility Residential Services
Send via FAX to **(520) 694-0599**

MEMBER INFORMATION

Name:____Date of Birth: ____________________________

Street Address:____ City: ________________Zip Code:____________

AHCCCS ID:____

Outpatient Provider:____ Phone Number:_____________________

Current DSM Diagnoses & Codes:____

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Current Medical Diagnoses/Conditions: ____

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☐ Court Ordered Evaluation ☐Court Ordered Treatment ☐Voluntary

▪ Please indicate why proper treatment of the person's behavioral health condition requires services on a hospital or inpatient basis under the direction of a physician.

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▪ Please indicate why the requested service can reasonably be expected to improve the person's condition or prevent further regression so this level of service will no longer be needed.

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▪ Please indicate why outpatient resources available in the community do not meet the treatment needs of this person.

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Proposed Facility:____________________________________Requested Admission Date: _____________________

Requested Service Dates: From:___________________To:_______________Discharge:________________________

Facility UM Contact:___________________________________Phone #: ____________________________________

I am aware of the member's condition and have been provided sufficient information to determine this level of care is appropriate.

Physician's Signature:_______________________________Print Name:__________________________Date:____________

PM Form 3.12.1 Certification of Need (CON)

Rev. 10/1/2024