Behavioral Health LOC Transfer Notification Form

Complete within 24 hours of transfer and include supporting clinical documentation.

Member Name:	Member ID:	Date of Birth:
Submitting Facility:		Authorization Number:
Receiving Facility:		Transfer Date:

Current LOC (From):

☐ Acute ☐ Subacute/RTU ☐ PRTF/RTC ☐ Other: _____

Current LOC (To):

☐ Acute ☐ Subacute/RTU ☐ PRTF/RTC ☐ Other: _____

Return to Original Facility?

☐ Yes ☐ No ☐ Unknown If Yes, Return Date: _____

Reason for Transfer:

☐ Higher LOC ☐ Needed ☐ Lower LOC ☐ Bed Availability

☐ Other: _____

Additional Notes:

Submit via: ☐ Fax 866-535-6974 ☐ Availity