SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Alice Gleghorn, PhD
Director

Substance Use Disorder (SUD) Residential Treatment Authorization

Treatment Facility: _____ ASAM Level of Care: _____

Client Number: _____

The above client is approved for an initial (30) day admission to Residential SUD Treatment at the above named treatment facility. A Comprehensive Assessment has been completed and reviewed by QCM and it has been determined that the client meets Medical Necessity for above ASAM Level of Care, Residential SUD Treatment. Please submit this form to BwellQCMADP@sbcbwell.org or fax to (805) 681-5117.

Requesting Staff: _____Signature: _____ Date: _____

FOR QCM ADP STAFF ONLY:

QCM ADP Reviewer: _____Signature: _____ Date: _____

Approved: _____Denied: _____

Reason for Denial:

_____

_____

** Should the assigned QCM coordinator deny this request, or authorize less time than requested, QCM or other assigned staff will issue a written NOABD (Notice of Adverse Benefit Determination) to the provider and the beneficiary when this decision is made.*

Revised: February 6, 2019