



**SUBMIT TO:**  
 Utilization Management Department  
 PHONE 1-866-534-5976 FAX 1-866-535-6974

# Substance Use Disorder (SUD) Concurrent Review Form (Adult)

## BILLING PROVIDER

Facility: \_\_\_\_\_ UR/Phone # \_\_\_\_\_ LOC: \_\_\_\_\_  
 Fax #: \_\_\_\_\_ Date/Time of Review: \_\_\_\_\_

## DIAGNOSTIC AND TREATMENT INFORMATION

Primary Diagnosis: \_\_\_\_\_

Secondary: \_\_\_\_\_

Clinical Notes:

Group Notes:

## UDS

## MEDICATIONS

## ASAM DIMENSION 3

## STATE OF CHANGE

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**ASAM DIMENSION 5**

**ASAM DIMENSION 6**

Discharge Plan: \_\_\_\_\_

Discharge Planner: \_\_\_\_\_ Phone #: \_\_\_\_\_

Discharge Barriers: \_\_\_\_\_

Task Sent to UM: \_\_\_\_\_

LCD: \_\_\_\_\_