Banner University Health Plans
Banner – University Family Care

BANNER UNIVERSITY HEALTH PLAN
RE-CERTIFICATION OF NEED (RON)

1) For persons 21 years of age or older, a RON must be completed every 60 days.
2) For persons age 20 years or younger, the treatment plan must be completed and reviewed every 30 days. The completion and review of the treatment plan meets the requirement for the recertification of need.

DATE AND TIME OF RON:_____@_____☐a.m. ☐p.m.

Type of Service Requested: ☐ Hospital/ IMD ☐ Hospital/ Non IMD
☐ Behavioral Health Inpatient Facility Residential Services (BHIF-RTC)
Send via fax to BUHP PA (520) 874-3411

MEMBER INFORMATION

Name:_____Date of Birth: _____

Street Address:_____City:_____Zip Code:_____

AHCCCS ID: _____

Outpatient Provider:_____Phone Number:_____

Current DSM - 5/ICD 10 Diagnoses & Codes:_____

_____

Current Medical Diagnoses/Conditions: _____

_____

☐Court Ordered Evaluation ☐Court Ordered Treatment ☐Voluntary

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

_____

_____

▪ 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.

_____

_____

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

_____

_____

FACILITY INFORMATION:

Facility Name:_____Date of Admission: _____

Facility Phone #:_____Facility Contact: _____

Requested Service Dates: From:_____To: _____

Discharge Date: _____

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

Behavioral Health Medical Professional's Signature:_____Print Name:_____ Date:_____