BlueCross BlueShield of North Carolina

BlueCross BlueShield Federal Employee Program

Fax: 866-987-4159

Residential Treatment for Behavioral Health

(for psychiatric, substance use disorder and eating disorder needs)

AUTHORIZATION REQUEST

Submission of this form is only a request for services and does not guarantee approval. Incomplete forms may delay processing. All NC Providers must provide their 5-digit Blue Cross Blue Shield of North Carolina (Blue Cross NC) provider ID# below.

Date of Request	Patient Name	Patient Blue Cross NC ID Number	Patient Date of Birth

Facility UR/DC Planner Contact	Phone #	Fax #

Requesting/Ordering Provider Information		Facility Information	
Provider Name		Facility Name	
Provider #, Tax ID # or NPI		Facility Tax ID # or NPI	
Street, Bldg., Suite #		Street, Bldg., Suite #	
City/State/Zip code		City/State/Zip code	
Phone #			
Fax #			

Current DX – Please list ICD-10 codes(s), Diagnosis Name, Specifier (if applicable)

ICD-10 Code _____ DX Name _____ Specifier _____
ICD-10 Code _____ DX Name _____ Specifier _____
ICD-10 Code _____ DX Name _____ Specifier _____

Residential Treatment Center Licensure Information

- **Prior to admission into a Residential Treatment Center the member must be enrolled in Case Management and agree to a preliminary treatment and discharge plan with the provider.**
- **If these criteria are not met, there is no available RTC benefit.**

Type of N.C. License Held (From NC Administrative Code):	
Is member enrolled with FEP Case Management?	☐ **Yes** ☐ **No** If NO, please contact FEP Case Management @ 888-234-2415 to enroll in the Case Management Program
Is your facility operational 24 hours per day, 7 days per week (24/7)?	☐ **Yes** ☐ **No**
Does your licensure require clinical staff to be present 24/7?	☐ **Yes** ☐ **No**

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Does your licensure require clinical staff during day hours but on call during sleep hours?	☐ Yes ☐ No
Is your facility accredited?	☐ Yes ☐ No
Do you have a copy of your facility NC State License and Accreditation to submit and attach with this request?	☐ Yes ☐ No

**** For Initial Authorization Requests Only ****

Approval must be obtained in advance of admission – failure to do so may result in reimbursement denial

Please fax in current clinical records (must include serial vital signs and withdrawal scale scores from prior 72 hours) AND treatment plans AND complete Discharge Summary upon discharge from treatment center.

Requested auth start date		Anticipated Length of Stay	
Reason for Current Admission Request	☐ Eating Disorder ☐ Substance Abuse Disorder ☐ Other medical or mental health condition: _____		
Is the patient currently in the Inpatient Setting?	☐ YES Inpatient Facility Name: _____ ☐ NO Patient Current Location:		
Acuity Assessment	Does the patient currently require, or is the patient anticipated to require physical restraint or seclusion? ☐ YES ☐ NO Does the patient require around-the-clock medical or nursing monitoring for treatment of withdrawal or other medical conditions? ☐ YES ☐ NO IF YES, are intensive treatment and resources of an inpatient hospital anticipated? ☐ YES ☐ NO		

Withdrawal Assessment – to be completed ONLY for SUD admission or if SUD is a currently occurring comorbid dx. (providers are asked to calculate the score)

ASAM Sore: _____

Please include serial Vital Signs and Withdrawal Assessment Scores for Substance Use related admissions (COWS/CIWA/BAWS)

Date			
Time			
Heart Rate			
Blood Pressure			
Temperature			
Please check W/D assessment criteria used and indicate Score ☐ CIWA ☐ COWS ☐ BAWS			
Symptoms & Severity			

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Pertinent Medical History (active co-occurring medical conditions)	
Current Medications (dosages, duration)	☐ Please indicate if including as a separate attachment if necessary.
Current psychological therapy (type, frequency, duration)	
Treatment History	**Please provide details related to prior treatment history and response, including service category type (i.e. Inpatient, Residential Treatment, Partial Hospitalization, Intensive Outpatient Program, regular outpatient therapy).** **☐ Please indicate if including as a separate attachment if necessary.**

Service Category	Dates	Reason for Admission	Response

Please list psychopharmacologic agents that member has been prescribed and trialed

Drug	Drug Class	Length of Trial/Start and End Dates	Max Dose	Member Response

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Patient risk or severity of behavioral health disorder; please check all applicable reasons and document clinical findings:	☐ **Imminent danger to SELF – include details of current thoughts/actions for suicide attempt and/or self-harm; current intent, plans, and/or means for suicide attempt or self-harm; current risk factors for completing suicide attempt and/or self-harm; withdrawal assessment scores (CIWA or COWS); and if applicable, dates, summary and contributing factors for prior attempts of suicide and/or self-harm:** ☐ **Imminent danger to OTHERS – Include details of current thoughts/actions for harm to others; current intent, plans, and/or means for harm to others; current risk factors for completing harm to others; and if applicable, dates, summary and contributing factors for prior acts of harm to others:** ☐ **Inability to care for self – include description of missed work/school obligations; inability to attend to activities of daily living; changes in weight, hygiene; etc.:** ☐ **Support assessment – include resources and relationships available at home and within social networks, and coping skills necessary to achieve recovery:** ☐ **Evidence for why outpatient treatment (partial hospitalization, intensive outpatient, or regular outpatient) is not a sufficient or safe alternative to residential treatment center care:**
Current Treatment Goals	**Documentation should include the proposed treatment plan interventions and goals; rationale/benefits of residential level of care versus a less intensive level of care (i.e. outpatient treatment); and expected patient participation and adherence:**
Anticipated Discharge Plan and Needs	

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Assessment of patient risk or severity of substance-related disorder (to be completed only for substance use disorder admission)	**Severity of substance-related disorder - include types of substances being used; what DSM-5 criteria for substance use disorder that are met; potential for relapse or continued use outside of a residential treatment setting; and motivation for change and recovery:** **Self-care assessment – include ability to attend to activities of daily living, functional status in the home, school/work and social settings:** **Support assessment – include resources and relationships available at home and within social networks, and coping skills necessary to achieve recovery:** **Evidence for why outpatient treatment (partial hospitalization, intensive outpatient, or regular outpatient) is not a sufficient or safe alternative to residential treatment center care:**

Assessment of patient risk or severity of eating disorder (to be completed only for eating disorder admission)	**Primary Care Provider: _____ Date of Last Appt: _____** **Registered Dietician: _____ Date of Last Appt: _____** **Nutritionist: _____ Date of Last Appt: _____** **Severity of eating disorder - include details of calorie intake, restrictive eating behavior, binge/purge frequency, motivation for change/recovery:** **Medical interventions and clinical supervisory needs for addressing eating disorders and weight-related behaviors:**

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	Ability to care for self– include activities of daily living, functional status in the home, school/work and social settings: **Supports– include resources and relationships available at home and within social networks, and coping skills necessary to achieve recovery:**
Clinical assessment and medical management of eating disorder	**Clinical symptoms of eating disorder – include BMI, vital signs, lab abnormalities, EKG results, other medical complications, and management interventions:** **Active co-occurring medical conditions and any required management:** **Active co-occurring mental health or substance use disorders:** **Other pertinent information:**
An URGENT review of services may be requested when, in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, believes application of the timeframe for making routine or nonlife - threatening care determinations could seriously jeopardize the life, health or safety of the member or others. **Does the overseeing physician consider this an URGENT request? ☐ YES ☐ NO**	
If YES is selected, please include rationale of member's current condition, requiring URGENT review:	

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By signing below, I certify that I have appropriate authority to request prior authorization and certification for the item(s) indicated on this request and that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in the patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available. Finally, I certify that I've completed this form in its entirety and I understand that an incomplete form may delay processing.

Signature: _____ Date: _____

Fax this form with required documentation to Blue Cross NC Federal Employee Program Behavioral Health @ 866-987-4159.

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