BlueCross BlueShield of North Carolina

Use for Commercial Members
Fax: 866-987-4161

Eating Disorder
Inpatient or Residential Treatment
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 Location	
Provider Name		Facility Name	
Provider #, Tax ID # or NPI		Facility PPN#, 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 _____

**** 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 AND treatment plans AND complete Discharge Summary upon discharge from treatment center.

Level of Care Requested (check one)	☐ Inpatient Hospital ☐ Residential Treatment		
Requested auth start date		Anticipated Length of Stay	
For RTC admissions ONLY: Is the patient currently in the Inpatient Setting?	☐ YES Inpatient Facility Name: _____ ☐ NO Patient Current Location: _____		
Health Care Provider Information	Primary Care Provider: _____ Date of Last Appt: _____ Registered Dietician: _____ Date of Last Appt: _____ Nutritionist: _____ Date of Last Appt: _____		

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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**
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)	

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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

Assessment of patient risk or severity of eating disorder

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:

Ability to care for self– include activities of daily living, functional status in the home, school/work and social settings:

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	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:**

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:**
Discharge Plan	**Documentation should include anticipated discharge plans, needs and/or barriers to discharge:**

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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:

Residential Treatment Center Licensure Information to be completed for Out-of-Network Facilities

- **An RTC is considered out-of-network if not specifically participating with Blue Cross NC OR if the RTC is not participating with the Host states Blue Card network.**
- **If these criteria are not met, there is no available RTC benefit.**

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**
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 State License and Accreditation to submit and attach with this request?	☐ **Yes** ☐ **No**

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 Commercial Behavioral Health @ 866-987-4161.

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