BlueCross BlueShield of North Carolina

Use for Commercial and SHP Members

Fax: 866-987-4161

Residential Treatment for Behavioral Health

(Not to be used for substance or eating disorders – please see separate request form)

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 Member ID number	Patient Date of Birth

Facility UR/DC Planner Contact	Phone #	Fax #

Admitting/Ordering Provider Information		Facility Information	
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 #		Phone #	
Fax #		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 ________________________

PLEASE SUBMIT COPY OF CURRENT LICENSURE FOR REVIEW WITH INITIAL REQUEST

** For Initial Authorization Requests Only ** Approval must be obtained in advance of admission – failure to do so may result in reimbursement denial Please send 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	
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

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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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Assessment of patient risk or severity of substance-related disorder	☐ **Imminent danger to SELF – includes 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;** ______________________________ ☐ **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:** ______________________________
Behavioral health disorder is present and appropriate for residential care: please check all applicable reasons and document clinical findings	☐ **Psychiatric, substance use, or other co-occurring conditions (include descriptions of severity and standard rating scales. e.g. PHQ-9, GAD, Columbia):** ______________________________ ☐ **Severe dysfunction in daily living (including self-care assessment and functional status in the home, school/work and social settings):** ______________________________

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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	______________________________

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 (RTC) 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 facility is non-participating with their local Blue Cross Blue Shield, facility must provide a COPY OF CURRENT LICENSURE FOR REVIEW.**
- **If current licensure is not provided, it is implied that the facility does not have an active license for RTC level of care, in which there is no benefit.**
- **In addition to the above, if the criteria below 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 licensed clinical staff to be present 24/7?	☐ Yes ☐ No
Does your licensure require licensed 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

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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 anincomplete 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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