



BlueCross BlueShield  
of North Carolina

# MEDICARE

## ***Behavioral Health Concurrent Review Form for Inpatient and Partial Hospital Programs***

Please note, this form applies to Healthy Blue + Medicare<sup>SM</sup> (HMO D-SNP) offered by Blue Cross and Blue Shield of North Carolina.

Please submit your request electronically using our preferred method at <https://www.availity.com>. If you use this form, fax it to **1-844-430-1702**.

Today's date:	
<b>Contact Information</b>	
Level of care:	
<input type="checkbox"/> Inpatient psychiatric	<input type="checkbox"/> Inpatient detox
<input type="checkbox"/> PHP mental health	<input type="checkbox"/> PHP substance use
<input type="checkbox"/> Inpatient substance use rehab	
Member name:	
Member ID or reference #:	Member DOB:
Member address:	
Member phone:	
Hospital account #:	
For child/adolescent, name of parent/guardian:	
Primary spoken language:	
Name of utilization review (UR) contact:	
UR contact phone number:	UR contact fax number:
Admit date:	
Admitting facility name:	Facility provider # or NPI:
Attending physician (first and last name):	
Attending physician phone:	Provider # or NPI:
Facility unit:	Facility phone:

Note: Availity is an independent company providing administrative support services for Healthy Blue + Medicare providers on behalf of Blue Cross and Blue Shield of North Carolina.

**<https://www.bluecrossnc.com/provider-home>**

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Discharge planner name:				
Discharge planner phone:				
<b>Diagnosis (psychiatric, chemical dependency and medical)</b>				
<b>Risk of Harm to Self (within the last 24 to 48 hours)</b>				
If present, describe:				
If prior attempt, date and description:				
Risk rating (Select all that apply.)				
<input type="checkbox"/> Not present	<input type="checkbox"/> Ideation	<input type="checkbox"/> Plan	<input type="checkbox"/> Means	<input type="checkbox"/> Prior attempt
<b>Risk of Harm to Others (within the last 24 to 48 hours)</b>				
If present, describe:				
If prior attempt, date and description:				
Risk rating (Select all that apply.)				
<input type="checkbox"/> Not present	<input type="checkbox"/> Ideation	<input type="checkbox"/> Plan	<input type="checkbox"/> Means	<input type="checkbox"/> Prior attempt
<b>Psychosis (within the last 24 to 48 hours)</b>				
Risk rating (0 = None, 1 = Mild or mildly incapacitating, 2 = Moderate or moderately incapacitating, 3 = Severe or severely incapacitating, N/A = Not assessed):				
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> N/A
If present, describe:				
Symptoms (Select all that apply.):				
<input type="checkbox"/> Auditory/visual hallucinations		<input type="checkbox"/> Paranoia		
<input type="checkbox"/> Delusions		<input type="checkbox"/> Command hallucinations		
<b>Substance Use (within the last 24 to 48 hours)</b>				
Risk rating (0 = None, 1 = Mild or mildly incapacitating, 2 = Moderate or moderately incapacitating, 3 = Severe or severely incapacitating, N/A = Not assessed):				
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> N/A

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Substance (Select all that apply.) <input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> PCP <input type="checkbox"/> LSD <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Opioids <input type="checkbox"/> Barbiturates <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Other (Describe.):		
Urine drug screen: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Result (if applicable): <input type="checkbox"/> Positive (If selected, list drugs.): <input type="checkbox"/> Negative <input type="checkbox"/> Pending		
For substance use disorders, please complete the following additional information, based on current assessment.		
<b>Current Assessment of American Society of Addiction Medicine (ASAM) Criteria</b>		
<b>Dimension (Describe or give symptoms.)</b>	<b>Risk rating</b>	
Dimension 1 (acute intoxication and/or withdrawal potential such as vitals, withdrawal symptoms)	<input type="checkbox"/> Minimal/none — not under influence; minimal withdrawal potential <input type="checkbox"/> Mild — recent use but minimal withdrawal potential <input type="checkbox"/> Moderate — recent use; needs 24-hour monitoring <input type="checkbox"/> Significant — potential for or history of severe withdrawal; history of withdrawal seizures <input type="checkbox"/> Severe — presents with severe withdrawal, current withdrawal seizures	
Dimension 2 (biomedical conditions and complications)	<input type="checkbox"/> Minimal/none — none or insignificant medical problems <input type="checkbox"/> Mild — mild medical problems that do not require special monitoring <input type="checkbox"/> Moderate — medical condition requires monitoring but not intensive treatment <input type="checkbox"/> Significant — medical condition has a significant impact on treatment and requires 24-hour monitoring <input type="checkbox"/> Severe — medical condition requires intensive 24-hour medical management	
Dimension 3 (emotional, behavioral or cognitive complications)	<input type="checkbox"/> Minimal/none — none or insignificant psychiatric or behavioral symptoms <input type="checkbox"/> Mild — psychiatric or behavioral symptoms have minimal impact on treatment <input type="checkbox"/> Moderate — impaired mental status; passive suicidal/homicidal ideations; impaired ability to complete ADLs <input type="checkbox"/> Significant — suicidal/homicidal ideations, behavioral or cognitive problems, or psychotic symptoms require 24-hour monitoring <input type="checkbox"/> Severe — active suicidal/homicidal ideations and plans, acute psychosis, severe emotional lability or delusions; unable to attend to ADLs; psychiatric and/or behavioral symptoms require 24-hour medical management	

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Dimension 4 (readiness to change)	<input type="checkbox"/> Maintenance — engaged in treatment <input type="checkbox"/> Action — committed to treatment and modifying behavior and surroundings <input type="checkbox"/> Preparation — planning to take action and is making adjustments to change behavior; has not resolved ambivalence <input type="checkbox"/> Contemplative — ambivalent; acknowledges having a problem and beginning to think about it; has indefinite plan to change <input type="checkbox"/> Precontemplative — in treatment due to external pressure; resistant to change
Dimension 5 (relapse, continued use or continued problem potential)	<input type="checkbox"/> Minimal/none — little likelihood of relapse <input type="checkbox"/> Mild — recognizes triggers; uses coping skills <input type="checkbox"/> Moderate — aware of potential triggers for MH/SA issues but requires close monitoring <input type="checkbox"/> Significant — not aware of potential triggers for MH/SA issues; continues to use/relapse despite treatment <input type="checkbox"/> Severe — unable to control use without 24-hour monitoring; unable to recognize potential triggers for MH/SA despite consequences
Dimension 6 (recovery living environment)	<input type="checkbox"/> Minimal/none — supportive environment <input type="checkbox"/> Mild — environmental support adequate but inconsistent <input type="checkbox"/> Moderate — moderately supportive environment for MH/SA issues <input type="checkbox"/> Significant — lack of support in environment or environment supports substance use <input type="checkbox"/> Severe — environment does not support recovery or mental health efforts; resides with an emotionally/physically abusive individual or active user; coping skills and recovery require a 24-hour setting
<b>Current Treatment Plan</b>	
<b>Medications</b>	
Have medications changed (type, dose and/or frequency) since admission? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give medication, current amount and change date:	
Have any PRN medications been administered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give medication, current amount and change date:	
<b>Member's Participation in and Response to Treatment</b>	
Attending groups? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Family or other supports involved in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Adherent to medications as ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Member is improving in (Select all that apply.):	
Thought processes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Affect	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mood	<input type="checkbox"/> Yes <input type="checkbox"/> No
Performing ADLs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Impulse control/behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No

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**Support System** (Include coordination activities with case managers, family, community agencies and so on. If case is open with another agency, name the agency, phone number and case number.)

**Discharge Plan** (Note changes and barriers to discharge planning in these areas and plan for resolving barriers. If a recent readmission, indicate what is different about the plan from last time.)

Housing issues:

Psychiatry:

Therapy and/or counseling:

Medical:

Wraparound services:

Substance use services:

Planned discharge level of care:

Expected discharge date:

**Submitter Information**

Submitted by:

Phone: