BlueCross BlueShield of North Carolina MEDICARE

Behavioral Health Initial Review

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

Please submit this form electronically at **https://www.availity.com**.This can also be submitted via fax to **1-844-430-1702**.

Submitter Information					
Date					
Contact information					
Level of Care					
☐Inpatient psych ☐Inpatient detox	☐ Inpatient chemical dependency	☐ Partial hospital program, low intensity	☐ Partial hospital program, high intensity		
Member Information					
Member name					
Member address					
Member ID or reference #		Member phone			
For child/adolescent, name of parent/guardian		Member DOB			
Patient identifying access code			Primary spoken language		
Facility and Provider Information					
Name of utilization review (UR) contact:		UR phone:			
Admission date:		UR fax number:			
☐Voluntary ☐Involuntary If involuntary, date of commitment:					
Admitting facility name:		Facility provider # or NPI:			
Attending physician (first and last name):		Attending physician phone:			
Provider # or NPI:	Facility unit:		Facility phone:		
Discharge planner name:		Discharge planner 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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Diagnoses (psychiatric, chemical dependency and medical)
Precipitant to Admission
Why is the treatment needed now? Please be as specific as possible.
Risk Assessment
Include medical necessity reasons for admission.
Current Legal Issues
Substance Use or Dependency
Current UA/lab results and use pattern (substances, last use, frequency, duration, sober history, vitals)

For substance use disorders, please complete the following additional information:

Current Assessment of American Society of Addiction Medicine (ASAM) Criteria	
Dimension (describe or give symptoms)	**Risk Rating**
Dimension one — acute intoxication and/or withdrawal potential such as vitals, withdrawal symptoms:	☐Minimal/none ☐Mild ☐Moderate ☐Significant ☐Severe
Dimension two — biomedical conditions and complications:	☐Minimal/none ☐Mild ☐Moderate ☐Significant ☐Severe
Dimension three — emotional, behavioral or cognitive complications:	☐Minimal/none ☐Mild ☐Moderate ☐Significant ☐Severe
Dimension four — readiness to change:	☐Minimal/none ☐Mild ☐Moderate ☐Significant ☐Severe
Dimension five — relapse, continued use or continued problem potential:	☐Minimal/none ☐Mild ☐Moderate ☐Significant ☐Severe
Dimension six — recovery living environment:	☐Minimal/none ☐Mild ☐Moderate ☐Significant ☐Severe

If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?
Previous Treatment
Include provider name, facility name, medications, specific treatment/levels of care and adherence.
Current Treatment Plan
Standing medications:
As-needed medications administered (not ordered):
Other treatment and/or interventions planned (including when family therapy is planned):
Support System
Include coordination activities with case managers, family, community agencies and others. If case is open with another agency, name the agency, phone number and case number.
Readmission Within Last 30 Days
☐Yes ☐No If yes, and readmission was to the discharging facility, what part of the discharge plan did not work and why?
Preliminary Discharge Plan
For example, patient will return home, go into outpatient care, partial hospital program, etc. Do not leave blank or put TBD.
Days requested or expected length of stay from today:

Submitter Information	
Submitted by:	Phone:

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.