

Behavioral Health Initial Review

Please note, this form applies to Healthy Blue + MedicareSM (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				
<input type="checkbox"/> Inpatient psych	<input type="checkbox"/> Inpatient chemical dependency	<input type="checkbox"/> Partial hospital program, low intensity	<input type="checkbox"/> Partial hospital program, high intensity	
<input type="checkbox"/> Inpatient detox				
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:		
<input type="checkbox"/> Voluntary <input type="checkbox"/> 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:	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension two — biomedical conditions and complications:	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension three — emotional, behavioral or cognitive complications:	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension four — readiness to change:	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension five — relapse, continued use or continued problem potential:	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension six — recovery living environment:	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe

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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.