BlueCross BlueShield of North Carolina

Behavioral Health Care Length of Stay Extension

Request for Length of Stay Extension for Inpatient or Residential Treatment Level of Care

Use for Commercial Members **Fax: 866-987-4161**

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 #

Current Authorization Reference #	
Facility Name	
Admitting/Ordering Provider Name	

For Length of Stay Extension Requests Only

Please supply only CURRENT clinical information and send in complete Discharge Summary upon discharge

****For patient's transitioning from Inpatient to Residential, a separate authorization is required****

Current Level of Care (please check one)	**Inpatient Care** ☐ **Psychiatric** ☐ **Eating Disorder** ☐ **Substance Use Disorder**	**Residential Treatment Care** ☐ **Psychiatric** ☐ **Eating Disorder** ☐ **Substance Use Disorder**	
Last Authorized Day		**Additional Days Requested**	
Clinical rationale and treatment plan for continued admission at this level of care:	**Documentation should include the proposed treatment plan interventions and goals including changes since last review; rationale/benefits of continued care at current level versus a less intensive level of care (i.e. outpatient treatment); progress or lack thereof; and expected patient participation or commitment status**		

Behavioral Health Care Length of Stay Extension

Patient Name	Blue Cross NC Patient ID number	Patient Date of Birth

Patient risk or severity of behavioral health disorder; please check all applicable reasons and document clinical findings:	**Does the patient currently require, or is the patient anticipated to require physical restraint or seclusion? ☐ YES ☐ NO** **☐ Imminent danger to SELF – include 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** **☐ 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.:**
Current Medications (Dosages, duration, adjustments)	
Current psychological therapy/ies being provided (type, frequency)	
Any new diagnoses being addressed	
Anticipated Discharge Plan	**Include plans for transition to next level of care, when this will likely occur and where/with whom treatment will be. Explain any delays/changes in plan since last review.** **☐Please indicate if attaching a separate Discharge Summary (if already discharged)**
Support System at Discharge	**Include resources and relationships available at home and within social networks, and coping skills:**

Barriers to Discharge	**Identify any barriers to discharge:** _____ **A Blue Cross NC Case Manager is available to make outreach while the member is still admitted at your facility to assist with discharge planning and transition of care. Please provide a phone number and ideal time for the Case Manager to speak with member.** _____
Withdrawal Assessment (only complete this box for Substance Use Disorder Admissions at Inpatient and RTC)	**Does the patient require around-the-clock medical or nursing monitoring for treatment of withdrawal or other medical conditions?** ☐ **YES** ☐ **NO** **Current ASAM Score (Please put N/A if not applicable):** _____ **Please include serial Vital Signs and Withdrawal Assessment Scores (COWS/CIWA/BAWS) Please indicate if including as a separate attachment if necessary.**

Date	
Time	
Heart Rate	
Blood Pressure	
Temperature	
Please check W/D assessment criteria used and indicate Score ☐ **CIWA** ☐ **COWS** ☐ **BAWS**	
Symptoms & Severity **Pertinent Labs** **IBW/BMI/Weight**	

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.

Version 061820.2