BlueCross BlueShield of North Carolina

Use for Commercial and SHP Members

Fax: 866-987-4161

Residential Treatment for Substance Use Disorder

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 DX _____

ICD-10 Code _____ Name _____ Specifier DX _____

ICD-10 Code _____ Name _____ Specifier _____

PLEASE SUBMIT COPY OF CURRENT LICENSURE FOR REVIEW WITH INITIAL REVIEW

**** For Initial Authorization Requests Only ****

Approval must be obtained in advance of admission – failure to do so may result in reimbursement denial

Please fax 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 ASAM Score: _____		

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Please include serial Vital Signs and Withdrawal Assessment Scores (COWS/CIWA/CIWA-B- Please submit forms)
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<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Date</td><td></td><td></td><td></td></tr>
<tr><td>Time</td><td></td><td></td><td></td></tr>
<tr><td>Heart Rate</td><td></td><td></td><td></td></tr>
<tr><td>Blood Pressure</td><td></td><td></td><td></td></tr>
<tr><td>Temperature
Withdrawal Assessment Criteria used:
☐ CIWA
☐ CIWA-B
☐ COWS</td><td></td><td></td><td></td></tr>
<tr><td>Symptoms & Severity</td><td></td><td></td><td></td></tr>
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<tr><td>Pertinent Medical History (active co-occurring medical conditions)</td><td></td></tr>
<tr><td>Current Medications (dosages, duration)</td><td>☐ Please indicate if including as a separate attachment if necessary.
_____
_____
_____
_____</td></tr>
<tr><td>Current psychological therapy (type, frequency, duration)</td><td>_____
_____
_____</td></tr>
<tr><td>Treatment History</td><td>
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.
<table>
<tr><th>Service Category</th><th>Dates</th><th>Reason for Admission</th><th>Response</th></tr>
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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

Assessment of patient risk or severity of substance-related disorder	**Severity of substance-related disorder - include types of substances being used; what DSM-5 criteria for substance use disorder that are met; potential for relapse or continued use outside of a residential treatment setting; and motivation for change and recovery:** _____ _____ _____ _____ **Self-care assessment – include ability to attend to activities of daily living, functional status in the home, school/work and social settings:** _____ _____ _____ _____ _____ **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:** _____ _____ _____ _____ _____

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Withdrawal assessment and medical management	**Signs or symptoms of withdrawal – include CIWA or COWS assessment score and management interventions:**_____ _____ _____ _____ **Active co-occurring medical condition(s) and any required management:**_____ _____ _____ _____ **Active co-occurring mental health disorder(s) and any required management (Please include descriptions of severity and standard rating scales for mood symptoms/suicide risk assessments. e.g. PHQ-9, GAD, Columbia) :**_____ _____ _____
Medication Assistant Treatment (MAT)	☐ **Yes- Medication Name**_____**/ Will MAT be offered upon D/C**_____ ☐ **No**
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: _____
_____
_____
_____

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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**

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.

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