of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402

bcbst.com

Commercial

Psychiatric Clinical Service Authorization Request Form

Please complete this form for both initial and concurrent requests and fax to **1-800-496-9600** or submit online authorization requests and concurrent review updates through **Availity**®.

☐ Initial Request - Complete all sections for INITIAL requests.

☐ Concurrent/Continued Stay Review – Reference/Authorization # _____

- Inpatient Request
  - ☐ Psych Residential
  - ☐ Psych Acute*
- Outpatient Request
  - ☐ Psych Partial Hospitalization*
  - ☐ Psych Psychiatric Intensive Outpatient Program (IOP)*
  - ☐ Electroconvulsive Shock Treatment (ECT)
  - ☐ Other (Specify) _____

Requested Start Date for this authorization: _____

Number of Days/Sessions _____ Frequency Requested: _____

Estimated Discharge Date _____

* Auto-auth for this level of care is available through Availity.

Member Information

Member Name: _____ Member ID#: _____

Date of Birth: _____ Member Phone Number: _____

(If applicable) Parent/Guardian Name: _____

DSM-5/ICD-10 Diagnosis Codes: _____

Co-morbidities (medical conditions): _____

Treating Provider and Facility Information

Ordering Physician/Clinician: _____

Provider ID#/NPI: _____

Tax ID: _____

Address: _____

Phone#: _____ Fax#: _____

Facility/Group Name: _____ Provider ID#/NPI: _____

Address: _____

Phone#: _____ Fax#: (If different from above) _____

Utilization Review (UR) Contact: _____

UR Contact #: _____ Contact email address: _____

UR Fax number: _____

Clinical Information (if concurrent review please see section below)

Date of evaluation/assessment:

Previous Treatment History:

Presenting Problem (description of acuity, presenting symptoms, nature of suicide attempts or aggression, need for medical attention for members or others, maladaptive behaviors):

Precipitant (stressors, triggers for behaviors, frequency, date of last occurrence):

Symptoms related to diagnosis:

Danger to Self or Others:

- Suicidal Ideation: ☐ Yes ☐ No

  Plan: _____

  Intent: _____

  Means: _____

- Homicidal Ideation: ☐ Yes ☐ No

  Intended Victim:_____ Victim Notified? ☐ Yes ☐ No

  If no, why not?_____

  Means/Access: _____

  History of attempts/aggression (dates if known): _____

  _____

• Psychosis: ☐ Yes ☐ No

If yes, describe delusions, hallucinations, command hallucinations and/or thought disorder.
If first episode, have neurological causes been ruled out?

• Baseline: _____

• UDS/BAL: _____

• MSE: _____

• Other behaviors that constitute risk to self or others:

Complete sections marked with an asterisk * for concurrent requests.

Psychosocial Factors: (home environment, family/social support, family issues, history of abuse/trauma, occupational/school problems, legal/social service involvement, current/history of substance abuse, UDS results)

*Medications (name, dosage, frequency)

*Medication Compliant? ☐ Yes ☐ No Barriers? _____

Treatment Plan/Goals:

*Discharge Plan (stepdown plan and disposition):

CONCURRENT REVIEW: Date_____

(i.e. updated MSE, barriers to discharge, pertinent clinical information, justification for continued stay, individual, family, and group session)

*Medications (name, dosage, frequency)

*If no progress toward stabilization and discharge readiness behavior, how will the treatment plan be changed?

*Discharge Plan (step down plan and disposition):

*Discharge Readiness Behavior? _____

*What progress has been made toward stabilization and discharge readiness since last review?

Include additional information below or attach additional clinical to fax.

By submitting this request, you're confirming that you've provided all clinical information available pertinent to this request and you're requesting the decision be made based on information provided in your submission.

Contact the eBusiness Marketing team for all your BlueCross BlueShield of Tennessee training needs by calling 423-535-5717 option 2 or emailing eBusiness_marketing@bcbst.com.