Substance Use Disorder (SUD) Clinical Service Authorization Request Form

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

☐ **Initial Request –** *Complete all sections for INITIAL requests.*

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

Complete sections marked with an asterisk for concurrent requests.*

- ☐ SUD Residential
- ☐ Inpatient Detox ASAM 4.0
- ☐ SUD Residential Detox 3.7
- ☐ SUD Outpatient Request
  - ☐ SUD Partial Hospitalization
  - ☐ SUD IOP
  - ☐ Other (Specify)

Requested Start Date for this authorization: _____

*Number of Days/Session: _____ Frequency Requested: _____

Estimated Discharge Date: _____

Did the member seek treatment at the Emergency Room prior to this admission? ☐ Yes ☐ No

If yes, name of hospital: _____

Member Information

Member Name: _____ Member ID#: _____

Date of Birth: _____ Member Phone Number: _____

Parent/Guardian Name (if applicable): _____

DSM-5/ICD-10 Diagnosis Codes: _____

Co-morbidities (medical conditions): _____

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Treating Provider and Facility Information

Ordering Physician/Clinician: _____

Provider ID#/NPI: _____ Tax ID: _____

Address: _____

Phone#: _____ Fax#: _____

Facility/Group Name: _____

Provider ID#/NPI: _____ Tax ID: _____

Address: _____

Phone#: _____ Fax#: _____

Utilization Review (UR) Contact: _____

UR Contact #: _____ UR Fax #: _____

Clinical Information (if for concurrent review, please see section below)**:**

Date of evaluation/assessment: _____

Presenting Problem:

Substance Use Disorder History: (drugs of choice, amounts, route of administration, frequency of use, age of first use, date of last use)

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Mental Status Exam and motivation for seeking treatment.

*__Vitals:__

Date of Vitals: _____ Blood Pressure: _____ Pulse: _____

Temperature: _____ Respirations: _____

CIWA Score: _____ COWS Score: _____

*Withdrawal Symptoms: _____

*UDS/BAL date/results: _____

Psychosocial Factors (home environment, family/social support, family issues, history of abuse/trauma, occupational/school problems, social service involvement, current/history of mental health issues, medical and legal consequences.):

Treatment History (including family involvement in treatment, previous attempts in treatment/outcomes):

*Treatment Plan/Goals:

Sponsor in place? ☐ Yes ☐ No

If yes, name of sponsor: _____

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*Medications (name, dosage, frequency):

*Medication Compliant? ☐ Yes ☐ No Barriers? _____

Has Medication Assisted Treatment been considered? ☐ Yes ☐ No

If yes, explain:

Concurrent Review Date: _____

(i.e. updated MSE, barriers to discharge, pertinent clinical information, justification for continued stay, vitals, COWS, CIWA, UDS, withdrawal symptoms)

*Medications (name, dosage, frequency, date added/changed):

*If no progress, what are the updates to the treatment plan?

*Discharge Plan (step down and disposition):

Continued on next page

Other relevant information:

Estimated length of stay, duration of service: _____

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 Availity. com registration and training needs by calling (423) 535-5717 option 2 or emailing eBusiness_marketing@bcbst.com.