of Tennessee

Commercial

Substance Abuse Clinical Service Authorization Request Form

Please complete this form for both initial and concurrent requests and fax to:

1-423-591-9498 or **1-800-496-9600**

OR

Submit online authorization requests via BlueAccess℠ anytime day or night.[1]

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

☐**Concurrent/Continued Stay Review –Reference/Authorization #** _____ *Complete sections marked with an asterisk* for concurrent requests.*

☐ Inpatient Request
- ☐ I/P Detox
- ☐ Substance Abuse I/P
- ☐ Substance Abuse Residential

☐ Outpatient Request
- ☐ Substance Abuse Partial Hospitalization
- ☐ Substance Abuse IOP
- ☐ Ambulatory Detox
- ☐ Other (Specify) _____

Requested Start Date for this authorization:

*Number of Sessions: _____ Frequency Requested: _____

Member Information

Member Name: _____ Member ID#: _____

Date of Birth: _____ Member Phone Number: _____

Provider Contact Information (Contact Person): _____

Title: _____ Phone#: _____ Fax#: _____

DSM-5/ICD-10 Diagnosis Codes: _____

Co-morbidities (medical conditions): _____

Treating Provider and Facility Information

Ordering Physician/Clinician: _____ Provider ID#/NPI: _____

Address: _____

Phone#: _____ Fax#: _____

Date of order:

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

Address: _____

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

Utilization Review (UR) Contact: _____

UR Contact #: _____ Contact email address: _____

Clinical Information

Date of evaluation/assessment:

Presenting Problem (drugs of choice, amounts, route of administration, frequency of use, age of 1st use, date of last use)

Precipitant (What stressor led to member seeking treatment? Why now? Consider American Society of Addiction Medicine (ASAM) dimensions and expected motivators:

Psychological, medical and legal consequences of use: _____

_____

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)

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

*Baseline (for concurrent reviews-describe movement toward baseline functioning):

*Treatment Plan:

What are the member's triggers? _____

List specific coping skill for each trigger: _____

Clean supports identified? _____

Home meeting or other support group identified? _____

Sponsor in place? _____

*Medications (name, dosage, frequency):

*Medication Compliant? ☐Yes ☐No Barriers? _____

*Discharge Readiness Behavior? _____

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

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

*Discharge Plan: _____

Other relevant information:_____

Estimated length of stay, duration of service: _____

Estimated discharge date:

Include additional information below or attach additional clinical to fax.

[1] - Contact the eBusiness Marketing team for all your BlueAccess registration and training needs by calling 423-535-5717 option 2 or emailing eBusiness_marketing@bcbst.com.