of Tennessee

BlueAdvantage (PPO)SM-
BlueChoice (HMO)SM

Psychiatric Clinical Service Authorization Request Form

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

423-591-9499 or **1-800-394-3053**

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
- ☐ Psych Acute I/P
- ☐ Psych Residential

☐ Outpatient Request
- ☐ Psych Partial Hospitalization
- ☐ Transcranial Magnetic Stimulation (TMS)
- ☐ Electroconvulsive Shock Treatment (ECT)
- ☐ 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 (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):

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?

_____

*Other Behaviors that constitute risk to self or others:

_____

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)

Complete this section only for Eating Disorder Treatment Requests.

*Height: _____ *Weight: _____

*% of Ideal Body Weight (IBW) or Current Body Mass Index (BMI): _____

*Orthostatic BP: Sitting: _____/_____Standing: _____/_____

*EKG, electrolytes, other lab info: _____

*Co-morbid medical conditions or symptoms: _____

*Co-morbid psychiatric symptoms: _____

Treatment Plan: (Goal weight at discharge, plan to monitor restriction, binging, purging or exercise, bathroom restrictions, caloric plan, family involvement, Cognitive Behavioral Therapy replacement skills):

Complete this section only for Problematic Sexual Behavior Requests.

Describe Problematic Sexual Behavior: _____

If there is a victim, does the member have continued contact? (Details?)

Has DCS been notified? ☐Yes ☐No

Has the member had a psychosexual assessment performed by a qualified provider to determine current risk?

☐Yes ☐No

What is the recommended level of care?

Treatment History (including family involvement in treatment):

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

*Treatment Plan (frequency/type of therapy, medication plan, behavior plan, family interventions)

If eating disorder treatment plan, see Eating Disorder section):

*If under 21, what assistance/support will family need to maintain behavior/treatment plan?

_____

*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.