BlueCross BlueShield of North Carolina

BlueCross BlueShield Federal Employee Program

Fax: 866-987-4159

Inpatient Psychiatric Care
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 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		Servicing provider or Facility #, Tax ID # or NPI	
Street, Bldg., Suite #		Street, Bldg., Suite #	
City/State/Zip code		City/State/Zip code	
Phone #			
Fax #			

Current DX – Please list ICD-10 codes(s), Diagnosis Name, Specifier (if applicable)

ICD-10 Code _____ DX Name _____ Specifier _____
ICD-10 Code _____ DX Name _____ Specifier _____
ICD-10 Code _____ DX Name _____ Specifier _____

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

Please send in updated clinical records and treatment plans for concurrent review/extensions AND send complete Discharge Summary upon discharge from treatment center

Authorization Request type (check One) – Do NOT use this for RTC requests	**Psychiatric Admission** ☐ Emergent Admission ☐ Elective Admission – approval must be obtained in advance of admission	**Substance Use Disorder Admission** ☐ Emergent Admission ☐ Elective Admission – approval must be obtained in advance of admission

Requested auth start date		Anticipated Length of Stay	
Acuity Assessment	Is the admission the result of an involuntary commitment order? ☐ YES ☐ NO Does the patient currently require, or is the patient anticipated to require physical restraint or seclusion? ☐ YES ☐ NO		

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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: _____

Please include serial Vital Signs and Withdrawal Assessment Scores (COWS/CIWA/BAWS)

Date			
Time			
Heart Rate			
Blood Pressure			
Temperature			
Please check W/D assessment criteria used and indicate Score **☐ CIWA** **☐ COWS** **☐ BAWS**			
Symptoms & Severity			

Withdrawal Assessment – to be completed ONLY for SUD admission or if SUD is a currently occurring comorbid dx. (providers are asked to calculate the score)

ASAM Score: _____

Please include serial Vital Signs and Withdrawal Assessment Scores (COWS/CIWA/BAWS)

Date			
Time			
Heart Rate			
Blood Pressure			
Temperature			
Please check W/D assessment criteria used and indicate Score **☐ CIWA** **☐ COWS** **☐ BAWS**			
Symptoms & Severity			

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Pertinent Medical History (active co-occurring medical conditions)	
Current Medications (Dosages, duration)	☐ Please indicate if including as a separate attachment if necessary.
Current psychological therapy/ies (type, frequency, duration)	
Other pertinent past treatment history	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).
Past Pharmacologic Therapy	Please list psychopharmacologic agents that member has been prescribed and trialed

Service Category	Dates	Reason for Admission	Response

Drug	Drug Class	Length of Trial/Start and End Dates	Max Dose	Member Response

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Patient risk or severity of behavioral health disorder; please check all applicable reasons and document clinical findings:	**☐ Imminent danger to SELF – include details of current thoughts/actions for suicide attempt and/or self-harm; current intent, plans, and/or means for suicide attempt or self-harm; current risk factors for completing suicide attempt and/or self-harm; withdrawal assessment scores (CIWA or COWS); and if applicable, dates, summary and contributing factors for prior attempts of suicide and/or self-harm:** **☐ Imminent danger to OTHERS – include details of current thoughts/actions for harm to others; current intent, plans, and/or means for harm to others; current risk factors for completing harm to others; and if applicable, dates, summary and contributing factors for prior acts of harm to others:** **☐ Inability to care for self – include description of missed work/school obligations; inability to attend to activities of daily living; changes in weight, hygiene; etc.:** **☐ Psychiatric, substance use, or other co-occurring conditions (include descriptions of severity):**
Clinical rationale and treatment plan for admission to the inpatient level of care:	**Documentation should include the proposed treatment plan interventions and goals; rationale/benefits of inpatient level of care versus a less intensive level of care (i.e. outpatient treatment); and expected patient participation or commitment status _** **Support System - include resources and relationships available at home and within social networks, and coping skills:**
Discharge Plan or Summary	**☐ Please indicate if attaching a separate Discharge Summary (if already discharged)**

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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:	

Please note: Patients stepping down/transitioning to Residential Treatment after Inpatient require separate authorization

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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 @ 866-987-4159.

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