Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

BCN Behavioral Health Continuing Outpatient Treatment Request Form

Member number:	Member name:	Member DOB:

Fax completed form to: 1-866-364-7145

Authorization is not a guarantee of payment.

Treating clinician Name: ______________________ Type: ☐ MD/DO ☐ Fully licensed psychologist ☐ LLP* ☐ LPC* ☐ Licensed SW ☐ CNP ☐ Other_____

*Supervising provider name ______________________

The authorization is to be entered for (select one): ☐ An individual -- See (a), below. ☐ An OPC -- See (b), below. ☐ A group -- See (a) and (b), below.

(a) Treating clinician's or supervisor's* name ______________________ and individual (Type 1) NPI: ______________

(b) Organization's name: and organizational (Type 2) NPI: ______________

Place of service Street address: ______________________ City: ______________ State: ___

ZIP code: ________ Phone #: ______________ Fax #: ______________ Billing Tax ID: ______________

Member's treatment history

	Date first seen	Date last seen
This treatment episode		

Current frequency of therapy sessions: ☐ Weekly ☐ Every other week ☐ Monthly ☐ Other:

Total time (approximate) in treatment with this practitioner: ☐ Less than 1 year ☐ 1 to 2 years ☐ 2 to 5 years ☐ 5 years or more

Total cumulative time (approximate) in treatment with all practitioners: ☐ Less than 1 year ☐ 1 to 2 years ☐ 2 to 5 years ☐ 5 years or more

Current therapy modality ☐ N/A ☐ CBT ☐ DBT ☐ IPT ☐ Brief dynamic ☐ Exposure/response prevention ☐ Supportive ☐ Other ______________

Prior treatment type

Lifetime		Last 12 months	
MH:	SA:	MH:	SA:
☐ IP	☐ IP	☐ IP	☐ IP
☐ PHP	☐ PHP	☐ PHP	☐ PHP
☐ IOP	☐ IOP	☐ IOP	☐ IOP

Substance abuse/ dependence:

(Check Yes or No.)	Screened ?	Problem ?	12-step ?
Alcohol:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Illicit drug:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Prescription drug:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Current DSM-5 diagnosis (record diagnosis code(s) and description(s); related medical concerns; other psychosocial/contextual factors. See instruction for example.)

Current symptoms, functional impairment and significant changes since last review (Note: Symptoms must support diagnosis and must be of at least moderate severity.)

Current psychiatric medication management: 1. Prescriber's name ______________________

2. Prescriber's relationship to member: ☐ PCP ☐ Psychiatrist (this clinic) ☐ Psychiatrist (other clinic / practice) ☐ NP / PA

3. Current frequency of psychiatric visits: ☐ Weekly ☐ Every other week ☐ Monthly ☐ Other: ______________

4. Medications: ☐ None ☐ Acute phase ☐ Continuation phase ☐ Maintenance

List current psychotropic medications / any changes since last review:

Is member adhering to medications as prescribed? ☐ Yes ☐ No ______________________

continued on page 2

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Member number:	Member name:	Member DOB:

Goal(s)	**Objective measure(s)** (how goal is measured)	**Targeted discharge outcome(s) / score** (specific, observable, measurable)	**Current outcome(s) / score** (since last treatment plan review)
Example: “Remission of depressive symptoms” Example: “Decreased OCD symptoms”	Example: “PHQ-9”, "Beck", "Zung" Example: “Y-BOCS"	Example: “Will d/c when PHQ-9 score <5 for 2 consecutive mos.” Example: “Will d/c when Y-BOCS score <7 for 3 consecutive mos."”	Example: “PHQ-9 score currently = 7 and is decreasing” Example: “Y-BOCS score currently = 12 and is decreasing"”
1.	1.	1.	1.
2.	2.	2.	2.

Treatment adherence

Is member following all treatment recommendations? ☐ Yes ☐ No **If no, explain:** ______________________

Is member attending treatment regularly? ☐ Yes ☐ No / **Is member completing homework assignments?** ☐ Yes ☐ No ☐ Not applicable

Termination of treatment (return to prior level of functioning)

Target discharge date (month/year): __________ **Number of additional sessions requested:** __________ See page 3 for instructions on these questions

Is there a mutual understanding of the termination of tx? ☐ Yes ☐ No / **If not, why not?** ______________________

If treatment has been ongoing for 24 months or more, the record should show documented attempts to decrease tx frequency. Please select one:

☐ **The number of documented unsuccessful attempts is** _____ **- OR -** ☐ **There are no documented attempts. Please explain in “Comments.”**

Comments

Provider signature: ______________________ **Date:** __________ **Provider NPI:** __________ **Provider Tax ID:** __________

FOR BCN use only:
Additional visits approved _____ **Year-to-date sessions** _____ **Authorization no.** ______________________ **Date:** __________ **Initials** _____

See Instructions on page 3.

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Check the therapy type in which the member is currently involved.

Instructions / definitions / examples

- **NPI:**
  - If you are billing these services as an individual provider, provide your individual (Type 1) NPI.
  - If you are billing these services as an OPC, provide your organizational (Type 2) NPI.
  - If you are billing these services as a group, provide your individual (Type 1) and your organizational (Type 2) NPI.

  Note: If you are an LLP or LPC, the individual (Type 1) NPI you enter must be that of your supervisor.
- **TREATMENT HISTORY.** Provide an approximation of the time the member has spent in treatment during the most recent episode and cumulatively over the member's lifetime.
- **CURRENT THERAPY MODALITY.** Indicate the current treatment modality for psychotherapy, including but not limited to: CBT (cognitive behavioral therapy), DBT (dialectical behavioral therapy), IPT (interpersonal therapy), brief dynamic therapy, exposure/response prevention, supportive therapy or other.
- **PRIOR TREATMENT TYPE.** Check each level of care that the member has had prior to this current episode of care, during the member's lifetime and during the past 12 months. IP = inpatient (mental health hospitalization, substance abuse detox or residential); PHP = partial hospitalization program (5-6 days/wk, 6-8 hrs/day); IOP = intensive outpatient program (3 days/wk, 3 hrs/day)
- **CURRENT DSM-5 DIAGNOSIS.** An example of what to record and the format to use: "296.32 Major Depressive Disorder, recurrent , moderate; 303.90 Alcohol Use Disorder, moderate; insulin-dependent diabetic; chronic migraines; lack of family support; job jeopardy."
- **SUBSTANCE ABUSE / DEPENDENCE.** Check the appropriate box at each review. Each member should be screened for substance abuse at the initial evaluation and again as indicated by your clinical judgment.
- **CURRENT SYMPTOMS / FUNCTIONAL IMPAIRMENT / SIGNIFICANT CHANGES.** This should reflect the member's CURRENT status. If this is the FIRST treatment plan review, you may choose to list the symptoms/impairment that presented initially, and then the current level of impairment. For any subsequent reviews, please list only the symptoms/impairment since your last treatment plan. Examples: "Panic attacks 3x/week; avoids social interaction as result." "Intermittent passive SI on daily basis." "Difficulty functioning in the school setting – noncompliance with teacher requests, disruptive in class, failure to complete assignments." "Continued cravings for alcohol; attending AA weekly, but no sponsor; working on ID of relapse prevention plan."
- **CURRENT PSYCHIATRIC MEDICATION MANAGEMENT.** If the member is on psychotropic medication, it is understood that for best clinical practices the therapist will have collaborative contact with the prescribing physician. Document the prescriber's name and relationship to the member. Record the frequency of the psychiatric visits, the psychotropic medications prescribed and any changes in these prescriptions since the last review. Also indicate whether the member is adhering to the medication regimen.
- **GOALS.** Describe what the therapist and the member hope to achieve via therapy. Examples: "Decrease in panic attacks; able to manage anxiety more effectively." "Abstinence from alcohol/drug use x 3 months." Add other pertinent information in the "free text" area, if desired.
- **TREATMENT ADHERENCE.** Answer the questions as succinctly as possible to show how well the member is following treatment recommendations.
- **TERMINATION OF TREATMENT.** Based on your clinical assessment and the status of treatment, please identify the anticipated discharge date and the number of ADDITIONAL sessions that the member will need in the next 6 to 12 months of care. Be aware that authorizations are based in part on the type of plan the member has - specifically, whether the coverage extends over a plan year, a calendar year or 365 days. Answer the additional questions.
- The provider should **sign and date** the form and record his or her NPI and Tax ID Number before submitting it for review.

When you have completed this form, please FAX it to 1-866-364-7145. Sessions are authorized based on the clinical symptoms presented and are limited by benefit availability and medical necessity.