

Community Based Behavioral Health Services Request Form

This is a request to review if the treatment meets the medical necessity definition under the member's health benefit plan.

It does not confirm the patient is eligible for benefits. For Initial Services, the Provider must call to check benefits at:

Blue Cross Community Health PlansSM: 877-860-2837

Blue Cross Community MMAI (Medicare-Medicaid Plan)SM: 877-723-7702

For BCBSIL BCCHPSM please fax to **888-530-9809**. For BCBSIL MMAI fax to **312-233-4099**.

Date:		Check (only) One: <input type="checkbox"/> *Initial Request <input type="checkbox"/> **Concurrent Request	
Subscriber Name:		Date of Birth:	
Subscriber ID#:			
Address:	City:	State:	Zip:
Provider Name:	Provider Address:		NPI:
Is the provider registered with the IMPACT system? <input type="checkbox"/> Yes <input type="checkbox"/> No			
(All providers not registered with the IMPACT system, must call customer service for authorization)			
UR/Contact Name:		Phone:	
Service Information			
Check (only) One: <input type="checkbox"/> Assertive Community Treatment (H0039) <input type="checkbox"/> Community Support Team (H2016) <input type="checkbox"/> Psychosocial Rehabilitation (H2017)			
Service Code Requested:		Number of Units Requested:	
Date Member Initiated Services:	Total Units Utilized:	Start Date of Request:	
Average Time Spent with Member per Week <i>(ex. how often and for how long)</i> :			
Current Behavioral Health Diagnoses			
Primary: Code #:	Diagnosis:	Specifier:	
Secondary: Code #:	Diagnosis:	Specifier:	
Tertiary: Code #:	Diagnosis:	Specifier:	
Medications (Dosage and Frequency)			
Medication Name:	Dosage:	Frequency:	
Medication Name:	Dosage:	Frequency:	

Medications (Dosage and Frequency) <i>continued</i>		
Medication Name:	Dosage:	Frequency:
Medication Name:	Dosage:	Frequency:
Medication Name:	Dosage:	Frequency:
Medication Name:	Dosage:	Frequency:
Is the member adherent with medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Historical/Current Medical Issues: (*History - Initial Request Requirement Only)		
Additional Treatment Providers		
Medical Providers:		
Additional Behavioral Health Providers:		
Is the member adherent with outpatient appointments?		
If no, please outline steps to address non compliance.		
Significant Risk Factors		
Has member had any of the following in the past 6 months? Recent/Current Substance Abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: Psychiatric Hospitalizations: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: ER Visits: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: Mobile Crisis Events: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: Arrests/Incarcerations: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:		
Current Clinical Presentation (<i>summary detailing why the member is meeting Illinois Administrative Code medical necessity</i>) Please reference: www.dhs.state.il.us (<i>Refer to Provider Section for Information by Division of Mental Health</i>):		
Current Functional Impairments (<i>i.e. ability to attend to ADLs, etc.</i>):		
Current Cognitive Impairments:		
Location of services being provided to member (<i>e.g., home, facility, etc.</i>):		

MEASURABLE TREATMENT GOALS
Goal #1:
Progress towards goal: <i>(**Concurrent Request Requirement Only)</i>
Anticipated progress by next review:
Goal #2:
Progress towards goal: <i>(**Concurrent Request Requirement Only)</i>
Anticipated progress by next review:
Goal #3:
Progress towards goal: <i>(**Concurrent Request Requirement Only)</i>
Anticipated progress by next review:
Goal #4:
Progress towards goal: <i>(**Concurrent Request Requirement Only)</i>
Anticipated progress by next review:

MEASURABLE TREATMENT GOALS <i>(continued)</i>	
Goal #5:	
Progress towards goal: <i>(**Concurrent Request Requirement Only)</i>	
Anticipated progress by next review:	
Additional Comments Regarding Measurable Progress: <i>(**Concurrent Request Requirement Only)</i>	
Discharge/Transition to Lower Level of Care Plan <i>(Specify the anticipated lower level of care and what barriers currently exist that prevent that member from reasonably being able to be managed at that level.)</i>	
All clinical information must be received for authorization determination. Please confirm the following are included in your submission:	
Documents Included in Fax Transmission	Check If Included
Mental Health Assessment <i>(Updated within one year)</i>	<input type="checkbox"/>
Crisis Plan Completed <i>(Updated within one year)</i>	<input type="checkbox"/>
Individual Treatment Plan <i>(Updated within six months)</i>	<input type="checkbox"/>
LOCUS/Composite Score <i>(Updated within six months)</i>	<input type="checkbox"/>
My signature confirms that I, or the facility I represent, will provide the requested services.	
Signature:	Title:
Date:	