BlueCross BlueShield of Illinois

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 Plans℠ (BCCHP℠): 877-860-2837
Blue Cross Community MMAI (Medicare-Medicaid Plan)℠: 877-723-7702

After completing the form, please fax to **312-233-4099**.

Date:			
Check (only) One: ☐ *Initial Request ☐ **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? ☐ Yes ☐ No			
(All providers not registered with the IMPACT system, must call customer service for authorization)			
UR/Contact Name:		Phone:	
Service Information			
Check (only) One: ☐ Assertive Community Treatment (H0039) ☐ Community Support Team (H2016) ☐ 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 *(ex. how often and for how long):*			
Current Behavioral Health Diagnoses			
Primary: Code #:	Diagnosis:	Specifier:	
Secondary: Code #:	Diagnosis:	Specifier:	
Teritiary: Code #:	Diagnosis:	Specifier:	
Medications (Dosage and Frequency)			
Medication Name:	Dosage:	Frequency:	
Medication Name:	Dosage:	Frequency:	

Medications (Dosage and Frequency) ***continued***		
Medication Name:	Dosage:	Frequency:
Medication Name:	Dosage:	Frequency:
Medication Name:	Dosage:	Frequency:
Medication Name:	Dosage:	Frequency:

Is the member adherent with medications? ☐ **Yes** ☐ **No** ☐ **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: ☐ Yes ☐ No If yes, please explain:

Psychiatric Hospitalizations: ☐ Yes ☐ No If yes, please explain:

ER Visits: ☐ Yes ☐ No If yes, please explain:

Mobile Crisis Events: ☐ Yes ☐ No If yes, please explain:

Arrests/Incarcerations: ☐ Yes ☐ No If yes, please explain:

Current Clinical Presentation *(summary detailing why the member is meeting Illinois Administrative Code medical necessity)*
Please reference: **www.dhs.state.il.us** *(Refer to Provider Section for Information by Division of Mental Health)*:

Current Functional Impairments *(i.e. ability to attend to ADLs, etc.):*

Current Cognitive Impairments:

Location of services being provided to member *(e.g., home, facility, etc.):*

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

MEASURABLE TREATMENT GOALS ***(continued)***

Goal #5:

Progress towards goal: ***(**Concurrent Request Requirement Only)***

Anticipated progress by next review:

Additional Comments Regarding Measurable Progress: ***(**Concurrent Request Requirement Only)***

Discharge/Transition to Lower Level of Care Plan ***(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.)***

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 *(Updated within one year)*	☐
Crisis Plan Completed *(Updated within one year)*	☐
Individual Treatment Plan *(Updated within six months)*	☐
LOCUS/Composite Score *(Updated within six months*	☐

My signature confirms that I, or the facility I represent, will provide the requested services.

Signature:	Title:
Date:	