BlueCross BlueShield of Illinois

THERAPEUTIC BEHAVIORAL ON-SITE SERVICES REQUEST FORM

Therapeutic Behavioral On-Site Services Request

To expedite the processing of your request, please complete all sections of the form.
Please include form with related medical records or claims submission.
Therapeutic Behavioral On-Site Services involve Community Based Services that are often billed as H codes or T codes (in this format: H#### or T####).
This is not a level of care that typically requires prior authorization, however, in order for us to verify the services you are billing and adjudicate your claim(s) we need this form filled out in its entirety.
Note: If this is a request for Retro or Post Service Clinical Review, it cannot be processed until providers have submitted a claim.

Member Name ____________________ **Member Date of Birth** ____________________

Subscriber Name ____________________ **Subscriber ID** ____________ **Group** ____________

Facility/Billing Provider Name ____________________ **NPI** ____________________

Address ____________________ **City** ____________ **State** ______ **Zip** ______

Rendering Provider Name ____________________ **NPI** ____________________

Rendering Provider License Type ____________________ **License Number** ____________________

Address ____________________ **City** ____________ **State** ______ **Zip** ______

Start Date of Therapeutic Behavioral On-Site Services ________ **Diagnosis Code(s):** ____________________

1. Requested CPT/HCPCS code ____________________ **Dates of service: From** __________ **to** __________

Number of units of this code billed within this time frame ____________________

A description of the physical service the member is receiving for this CPT/HCPCS code being billed
(i.e. counseling services, assessment, treatment planning, training/education, etc.)

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Duration of time for 1 unit *(if applicable)*	**Treatment Location**	**Attendance Type**	**Treatment Type**
☐ **15 min**	☐ **Home**	☐ **Individual**	☐ **Assessment**
☐ **30 min**	☐ **Clinic**	☐ **Family**	☐ **Therapy**
☐ **45 min**	☐ **School**	☐ **Group**	☐ **Skills Training**
☐ **60 min**	☐ **Other** __________	☐ **Other** __________	☐ **Other** __________
☐ **Other** __________			

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2. **Requested CPT/HCPCS code** ________________ **Dates of service: From** ________ **to** ________

Number of units of this code billed within this time frame ________________

A description of the physical service the member is receiving for this CPT/HCPCS code being billed
(i.e. counseling services, assessment, treatment planning, training/education, etc.)

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Duration of time for 1 unit *(if applicable)*	**Treatment Location**	**Attendance Type**	**Treatment Type**
☐ 15 min	☐ Home	☐ Individual	☐ Assessment
☐ 30 min	☐ Clinic	☐ Family	☐ Therapy
☐ 45 min	☐ School	☐ Group	☐ Skills Training
☐ 60 min	☐ Other ________	☐ Other ________	☐ Other ________
☐ Other ________			

3. **Requested CPT/HCPCS code** ________________ **Dates of service: From** ________ **to** ________

Number of units of this code billed within this time frame ________________

A description of the physical service the member is receiving for this CPT/HCPCS code being billed
(i.e. counseling services, assessment, treatment planning, training/education, etc.)

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Duration of time for 1 unit *(if applicable)*	**Treatment Location**	**Attendance Type**	**Treatment Type**
☐ 15 min	☐ Home	☐ Individual	☐ Assessment
☐ 30 min	☐ Clinic	☐ Family	☐ Therapy
☐ 45 min	☐ School	☐ Group	☐ Skills Training
☐ 60 min	☐ Other ________	☐ Other ________	☐ Other ________
☐ Other ________			

4. **Requested CPT/HCPCS code** ________________ **Dates of service: From** ________ **to** ________

Number of units of this code billed within this time frame ________________

A description of the physical service the member is receiving for this CPT/HCPCS code being billed
(i.e. counseling services, assessment, treatment planning, training/education, etc.)

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Duration of time for 1 unit *(if applicable)*	**Treatment Location**	**Attendance Type**	**Treatment Type**
☐ 15 min	☐ Home	☐ Individual	☐ Assessment
☐ 30 min	☐ Clinic	☐ Family	☐ Therapy
☐ 45 min	☐ School	☐ Group	☐ Skills Training
☐ 60 min	☐ Other ________	☐ Other ________	☐ Other ________
☐ Other ________			

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5. **Requested CPT/HCPCS code** ______________________ **Dates of service: From** __________ **to** __________

Number of units of this code billed within this time frame ______________________

A description of the physical service the member is receiving for this CPT/HCPCS code being billed
(i.e. counseling services, assessment, treatment planning, training/education, etc.)

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Duration of time for 1 unit *(if applicable)*	Treatment Location	Attendance Type	Treatment Type
☐ **15 min**	☐ **Home**	☐ **Individual**	☐ **Assessment**
☐ **30 min**	☐ **Clinic**	☐ **Family**	☐ **Therapy**
☐ **45 min**	☐ **School**	☐ **Group**	☐ **Skills Training**
☐ **60 min**	☐ **Other** __________	☐ **Other** __________	☐ **Other** __________
☐ **Other** __________			

6. **Requested CPT/HCPCS code** ______________________ **Dates of service: From** __________ **to** __________

Number of units of this code billed within this time frame ______________________

A description of the physical service the member is receiving for this CPT/HCPCS code being billed
(i.e. counseling services, assessment, treatment planning, training/education, etc.)

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Duration of time for 1 unit *(if applicable)*	Treatment Location	Attendance Type	Treatment Type
☐ **15 min**	☐ **Home**	☐ **Individual**	☐ **Assessment**
☐ **30 min**	☐ **Clinic**	☐ **Family**	☐ **Therapy**
☐ **45 min**	☐ **School**	☐ **Group**	☐ **Skills Training**
☐ **60 min**	☐ **Other** __________	☐ **Other** __________	☐ **Other** __________
☐ **Other** __________			

Other Comments

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My signature confirms that I am providing the requested services:

Signature ______________________________ **Date** ______________________