of Tennessee

Behavioral Health Outpatient Request Form

Please check the applicable line of business for this form:

- ☐ BlueAdvantage (PPO)℠
- ☐ BlueCare℠
- ☐ BlueCare Plus Tennessee
- ☐ CoverKids
- ☐ TennCare*Select*

☐ Check here if this member has a FIDE plan.

Level of care requesting (case type):
please check the appropriate level of care

- ☐ Partial hospitalization programming (PHP)
  - ☐ PHP — Mental health primary
  - ☐ PHP — Substance abuse primary (no precert required if in network)
- ☐ Intensive outpatient programming (IOP)
  - ☐ IOP — Mental health primary
  - ☐ IOP — Substance abuse primary (no precert required if in network)
- ☐ Comprehensive child and family therapy (CCFT)
  - ☐ Specialized CCFT
- ☐ Continuous treatment team (CTT)
  - ☐ Specialized CTT
- ☐ Family intervention treatment team (FITT)
- ☐ Psychological testing (see other specific form)
- ☐ Transcranial magnetic stimulation (TMS)
- ☐ Program of assertive community treatment (PACT)
- ☐ Outpatient routine psychiatry (no precert required if in network)
- ☐ Outpatient routine therapy (no precert required if in network)
- ☐ Applied behavior analysis (ABA) (see other specific form)
- ☐ Routine supported housing
- ☐ Enhanced supported housing
- ☐ Specialized supported housing
- ☐ Medically fragile supported housing
- ☐ Behavioral health respite
- ☐ Electroconvulsive therapy (ECT) (no precert required if in network)
- ☐ System of support (SOS)
- ☐ Project Transition
- ☐ Other_____

Member number: _____

Member name: _____

Member date of birth: _____

Member contact number: _____

Date request sent: _____

Initial: ☐ Yes ☐ No

Concurrent: ☐ Yes ☐ No

If concurrent, please list the authorization number and fill out the remainder of this section. Then, skip to concurrent review and the treatment/discharge planning section near the end of the form.

Authorization number: _____

Provider name: _____

Provider phone: _____

Provider fax: _____

Place of service: On campus outpatient hospital, off campus outpatient hospital or office:

Requesting clinician: _____

Clinician provider ID #: _____

Clinician NPI #: _____

Clinician address: _____

Treating clinician: _____

Clinician provider ID #: _____

Clinician NPI #: _____

Clinician address: _____

Requested facility: _____

Facility provider ID #: _____

Facility NPI #: _____

Facility address: _____

Psychiatric ICD-10 diagnosis codes:

1) _____

2) _____

3) _____

4) _____

5) _____

Medical ICD-10 diagnosis codes:

1) _____

2) _____

3) _____

4) _____

5) _____

Requested start date of service: _____

Units or number of days requesting: _____

Clinical information

Date when the patient initiated the request for this service: _____

For initial review, please see the sections below and fill out all that apply.

Describe the patient's current condition (including mental status and behavioral symptoms):

Suicidal ideation? (plans/means/intent) ☐ Yes ☐ No

Homicidal ideation? (plans/means/intent) ☐ Yes ☐ No

Psychosis? ☐ Yes ☐ No

Other symptoms/concerns:

Is there duty to warn? ☐ Yes ☐ No

Describe any history of attempts (suicidal attempts, homicidal attempts, or overall aggression towards others and/or property):

Precipitant:

Treatment history:

What is patient's baseline?

Why can the patient not be treated in a lower level of care at this time?

Medications	Dose	Frequency	Dates	Outcome

Medication adherence? ☐ Yes ☐ No

If no, what are the barriers to adherence?

Urinary drug screen (UBS) and/or blood alcohol (BAL) results: _____

Only fill out this section if the patient is under the age of 18.

Who has custody of the patient?

Is there any current Child Protective Services (CPS)/Department of Children's Services (DCS) involvement?

☐ Yes ☐ No

Do any current symptoms/behaviors occur in a school setting? ☐ Yes ☐ No

Is the school involved in the current treatment plan? ☐ Yes ☐ No

Is the patient enrolled in special education? ☐ Yes ☐ No

Only fill out this section if the patient has substance use issues.

Drug used	Amount of use	Frequency of use	Age of first use	Date of last use	Method of administration

Longest period of sobriety: _____

Vital signs:

Blood pressure: _____ Heart rate: _____ Temperature: _____

Does the patient have a history of seizures, delirium tremens (DTs) or blackouts? ☐ Yes ☐ No

Current withdrawal symptoms:

Psychological and/or legal consequences of substance use:

Substance use treatment history:

Support group involvement:

Patient's triggers:

Only fill out this section if the patient requires eating disorder services.

Patient height: _____

Patient weight: _____

% Ideal body weight (IBW): _____

Current BMI: _____

Orthostatic blood pressure: _____

Standing: _____

Sitting: _____

Pulse rate: _____

EKG, electrolytes and other lab information: _____

Goal weight/BMI: _____

Last known episode of bingeing/purging/withholding:

Triggers for bingeing/purging/withholding:

Precipitant(s):

Only fill out this section if the patient needs sexual offender related services.

Presenting problem:

How is the legal system and/or DCS involved?

When was the last time these behaviors occurred?

In what setting do these behaviors occur?

Is the school setting involved in current treatment plan? ☐ Yes ☐ No

Has a psychosexual assessment been completed prior to this request? ☐ Yes ☐ No

If yes, please attach the assessment.

Only fill out this section for concurrent review, then skip to the treatment and discharge planning section.

Has any progress been made in the patient's symptoms, behaviors or diagnosis since the last review? Please explain:

If no progress has been made, how will the treatment plan be changed?

Is there ongoing suicidal/homicidal ideations or psychosis? ☐ Yes ☐ No

Medication changes:

Has the patient's family been involved in their treatment (phone, education, family sessions or visitations)? Please explain:

Treatment and discharge planning section

List the goals for the patient/family:

What is the anticipated treatment plan for the patient?

Are there any limitations for family participation in treatment (transportation or legal)? If so, please explain:

Discharge plan:

Anticipated barriers to discharge:

Primary care physician name and efforts to coordinate care:

Ordering clinician with credentials (required in order to process): _____

Date of order: _____

Fax pre-certification numbers:

BlueAdvantage: 1-888-535-5243

BlueCare Plus Tennessee: 1-866-325-6694

BlueCare/TennCare*Select*: 1-800-292-5311

CoverKids: 1-800-851-2491

Provider service numbers:

BlueAdvantage: 1-800-841-7434

BlueCare: 1-800-468-9736

BlueCare Plus Tennessee: 1-800-299-1407

CoverKids: 1-800-924-7141

TennCare*Select*: 1-800-276-1978

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26PED4187200 (04/26)