Regence

Behavioral Health Utilization Management
Initial Request Form

This form is used to request inpatient, residential, partial hospitalization program (PHP) or intensive outpatient program (IOP) treatment.

Please submit via email: FAXBHRepository@regence.com or Fax: 888-496-1540.

Expedited request: I attest that this request meets the below definition by checking the expedited request box: ☐

Expedited is defined as: When the member or his/her provider believes that waiting for a decision within the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy.

Is this for a Medicare Preservice Benefit Organization Determination Request? ☐ Yes ☐ No

Today's Date:	Member ID #:

Request authorization:

Mental Health level of care requested

☐ Inpatient hospital (IP) ☐ Residential (RES) ☐ Partial Hospital (PHP) ☐ Intensive Outpatient (IOP)

☐ IP - eating dis. ☐ RES - eating dis. ☐ PHP - eating dis. ☐ IOP - eating dis.

Substance Use Disorder level of care requested

☐ ASAM 4 ☐ ASAM 3.7 ☐ ASAM 3.5 ☐ ASAM 2.5 ☐ ASAM 2.1 ☐ Other: _____

For PHP & IOP - specify program frequency (# of days per week):

Admit or projected start date: Has member admitted? ☐ Yes or ☐ No	Days Requested:	Estimated Length of stay:

Member information

Member Name:	Member DOB:
Member address:	Member phone #:

Name of parent/guardian if minor:	Member email:	Primary language:

Provider information

Please check one: ☐ Requesting / Prescribing Provider ☐ Rendering / Treating Provider

Provider name:	Tax ID #:

NPI #:	Office Phone #:	Office Fax #:

Mailing Address:	Provider Specialty:

Attending physician first and last name:	Attending physician phone #:

Who should we call for possible MD review? Name & Phone Number:

Facility information ☐ **Same as above**

Facility name:	Tax ID #:

NPI #:	Office Phone #:	Office Fax #:

Physical Address:

Attending physician first and last name:	Attending physician phone #:

Utilization Reviewer Information

UR/Contact Name:	Phone #:	Confidential voicemail ☐ Yes ☐ No	Fax #:

ICD-10 diagnoses update. Please indicate primary.

Precipitant to Admission

Patient Treatment History

Current Outpatient Providers or Facility care: (please include dates & contact information).

Past Outpatient Providers or Facility Care: (please include dates & contact information).

Risk Assessment / Functional Impairments

Co-occurring medical / physical illness

(Please explain how these are being addressed)

For Eating Disorders: Weight, BMI, Vitals

☐ Not applicable

Current assessment of American Society of Addiction Medicine (ASAM)

For substance use disorders, please complete the following information. ☐ Not applicable

Substance Use: please detail all substances used; amount, frequency, and date of last use.

Dimension 1. Acute intoxication and/or withdrawal potential.

Describe: (include vitals and withdrawal symptoms):
CIWA / COWS:
Vitals:

Dimension 2. Biomedical conditions and complications.

Describe:

Dimension 3. Emotional, behavioral, or cognitive complications.

Describe:

Dimension 4. Readiness to change.

Describe:

Dimension 5. Relapse, continued use or continued problem potential.

Describe:

Dimension 6. Recovery living environment. Describe:

Treatment Plan	
Treatment goals:	
Treatment interventions: (include family treatment and community referrals)	
Medications: (Please specify last medication appointment and current medications)	
Discharge Planning	
Discharge planner name:	Phone:
Aftercare plan:	
Please list any outstanding items needing attention for next review.	
Submitted by:	Phone: