bridgespan

Behavioral Health Utilization Management
Concurrent Request Form

Instructions:

- This form is used to request continued inpatient, residential, partial hospital, and intensive outpatient treatment.
- Please submit via email: FAXBHRepository@regence.com or Fax: 888-496-1540.

Today's Date:	Member ID #:	Current Authorization #:

Member information	
Member Name:	Member DOB:

Continued Authorization Request

Please choose only one level of care.

Mental Health - (includes eating disorder)

☐ Level 6 - Inpatient ☐ Level 5 - Residential ☐ Level 4 - Partial Hospital ☐ Level 3 - Intensive Outpatient

Substance Use Disorder

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

For PHP and IOP: specify program frequency (# of days per week): _____

Original Admit Date:	Start Date of Request:	Days Requested:	Estimated Length of stay:

Diagnosis: ICD-10 code and description.

Please indicate primary:

Utilization Reviewer			
UR / Contact Name:	Phone #:	Confidential voicemail ☐ Yes ☐ No	Fax #:
Who should we call for possible MD review? ☐ UR noted above ☐ Provider Name & Phone:			

Facility information ☐ **No Change** ☐ **See Changes below**		
Rendering Facility Name:	NPI #:	Tax ID #:
Treatment Facility Address:	Phone #:	Fax #:
Attending physician first and last name:	Attending physician phone #:	
Requesting Provider Name: ☐ Same as above	NPI #:	Tax ID #:
Provider Address:	Phone #:	Fax #:

Mental Health Treatment Update ☐ Not applicable

If no information is provided in a particular section, then I attest there is no significant clinical impairment.

Clinical updates since last review. (Please provide date of updated clinical information.)

For Eating Disorders: Weight. BMI. Vitals. ☐ Not applicable

Risk Assessment: ☐ None Reported

Functional Status: ☐ None Reported

Medical, Substance Use or Psychiatric Co-Morbidities: ☐ None Reported

Recovery Environment: (home / living environment and supports). ☐ None Reported

Previous treatment / Motivation for Treatment / Treatment engagement. ☐ None Reported

Substance Use Treatment Update: American Society of Addiction Medicine (ASAM) assessment. ☐ Not applicable

Dimension 1. Acute intoxication and/or withdrawal potential (please include CIWA / COWS / Vitals):

Dimension 2. Biomedical conditions and complications.

Dimension 3. Emotional, behavioral, or cognitive complications.

Dimension 4. Readiness to change.

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

Dimension 6. Recovery living environment.

Treatment Plan

Updated treatment goals / Progress toward goals:

Treatment interventions: (include family treatment and community referrals) (please include family session notes with submission).

Individual session frequency: _____.

Family session frequency: _____.

Psychiatric visit frequency: _____.

Updated Medications (Please specify last medication appointment and current medications)

Continued Stay Rationale - be specific about goals to be accomplished.

Discharge Planning	
Discharge planner name:	Phone:
Aftercare plan:	
Additional Information:	
Submitted by:	Phone: