Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

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: