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Behavioral Health Utilization Management
Concurrent Request Form

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

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

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

Request continued 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): ______________.

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

Member information

Member Name:	Member DOB:

Facility information ☐ **No Change** ☐ **See Changes below**

Facility name:	Tax ID #:

NPI #:	Office Phone #:	Office Fax #:

Physical Address:

Attending physician first and last name:	Attending physician phone #

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

Utilization Reviewer Information

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

ICD-10 diagnoses update. Please indicate primary.

Clinical Update since last review — symptoms, risk factors, functional impairments.
Please provide date of updated clinical information.

Individual & Family Sessions: (Specify date of last session and session content)

Co-occurring medical / physical illness updates

(Please explain how these are being addressed)

For Eating Disorders: Updated Weight, BMI, Vitals

☐ Not applicable

Updated assessment of American Society of Addiction Medicine (ASAM)
☐ **Not applicable**

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:

If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?

☐ Not applicable

Treatment Plan

Updated treatment goals / Progress toward goals:

Updated treatment interventions:

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:	
Please list any outstanding items needing attention for next review.	
Submitted by:	Phone: