

Chemical Dependency Child/Adolescent

Authorization Request Form

Authorization is not a confirmation of coverage or benefits. Benefits remain subject to all contract terms, benefit limitations, conditions, exclusions, and the patient's eligibility at the time services are rendered.

Fax Number: 1-800-851-2491

- | | |
|--|--|
| <input type="checkbox"/> Inpatient Request | <input type="checkbox"/> Outpatient Request |
| <input type="checkbox"/> Inpatient Detox | <input type="checkbox"/> Ambulatory Detox |
| <input type="checkbox"/> Substance Abuse Inpatient | <input type="checkbox"/> Substance Abuse Partial Hospitalization |
| <input type="checkbox"/> Substance Abuse RTC | <input type="checkbox"/> Substance Abuse IOP |

Instructions

Complete this form for both initial and concurrent requests for services.
For initial review, complete all items / For concurrent review, complete only items with asterisk*

Member Information

Member Name: _____ Member ID Number: _____

Date of Birth: _____ Age: _____

Diagnosis: (List all DSM-5 codes)

Physician and Facility Information

- | | |
|--|--|
| <input type="checkbox"/> Initial Request | <input type="checkbox"/> Concurrent Review |
|--|--|

Facility Name: _____

Facility NPI Number: _____ Facility Tax ID # _____

Ordering Physician/Practitioner Name: _____

Ordering Physician/Practitioner NPI Number: _____ Tax ID Number: _____

Date of Order: _____

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Certificate of Medical Necessity

Certification of Need (CON)

1st CON: Date _____ Time _____

2nd CON: Date _____ Time _____

Facility Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

UR Contact: _____ UR Phone Number: _____

Requested Start Date: _____ Date of Evaluation/Assessment: _____

Clinical Information

Date of Current Assessment: _____ *Date of admission: _____

Presenting Problem (drug(s) of choice, route of administration, amount of use, frequency of use, age of first use, date of last use etc.):

Precipitant (what stressor led to this? why now? consider ASAM dimensions & external motivators):

Psychological & Legal consequences of use:

*Baseline (for concurrent review, progress toward baseline):

*DSM 5 Diagnoses (Mental Health and Medical)-DSM:

*UDS & BAL results:

Treatment History (previous attempts at treatment & outcome):

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*Treatment plan

What are the member's triggers?

List specific coping skill or treatment plan for each:

Clean supports identified:

Sponsor in place? _____

Home meeting identified? _____

*Medications

*Medication adherence? Barriers to adherence?

*If concurrent review, what progress has been made?

*If concurrent review & no progress, how will the treatment plan be changed?

*Discharge Readiness Behavior (what specific behavior(s) will indicate readiness to discharge?)

*Discharge Plan

*PCP involvement and efforts to coordinate care:

*Other information:

*Estimated length of stay: _____

*Estimated discharge date: _____

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Monday through Friday

Call **1-888-416-3025** for **case management**
8 a.m. – 6 p.m. ET, Monday through Friday

Call **1-866-904-7477** for **24/7 Nurseline**
to get around-the-clock health information
from registered nurses

Call **1-800-999-1658** for the **Health Information Library** to hear recorded health
messages 24 hours a day

*We look forward to working with you and helping
your child be as healthy as possible!*



BlueCare Tennessee | 1 Cameron Hill Circle | Chattanooga, TN 37402 | bluecare.bcbst.com

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