of Tennessee

Mental Health Inpatient Request Form

Please check line of business for this form:

☐ BlueAdvantage (PPO)SM ☐ BlueCare Plus (HMO SNP)SM ☐ CoverKids
☐ BlueCareSM ☐ TennCare*Select*

Level of care requesting: (Please check the appropriate level of care.)

☐ Inpatient psychiatric acute hospitalization
☐ BH inpatient detox
☐ Substance abuse residential treatment
☐ Sub-acute hospitalization

Member number: ____________________
Member name: ____________________
Member date of birth: ____________________
Member contact number: ____________________

Date request sent: ____________________
Initial: ☐ Yes ☐ No
Concurrent: ☐ Yes ☐ No
If concurrent, please list auth number and fill out remainder of this section and then skip to concurrent review and treatment/discharge planning section towards bottom of form.
Auth number: ____________________

Provider name: ____________________
Provider phone: ____________________
Provider fax: ____________________

Place of service: Inpatient psychiatric facility

Requesting clinician: ____________________
Clinician provider ID #: ____________________
Clinician NPI #: ____________________
Clinician address: ____________________

Treating clinician: ____________________
Clinician provider ID #: ____________________
Clinician NPI #: ____________________

Clinician address: ____________________

Requested facility: ____________________

Facility provider ID #: ____________________

Facility NPI #: ____________________

Facility address: ____________________

Psychiatric ICD-10 diagnosis codes:

1) ____________________

2) ____________________

3) ____________________

4) ____________________

5) ____________________

Medical ICD-10 diagnosis codes:

1) ____________________

2) ____________________

3) ____________________

4) ____________________

5) ____________________

Requested start date of service: ____________________

Units or number of days requesting: ____________________

Clinical Information Section

(For initial review. Please see other applicable sections below and fill out all that apply.)

☐ Voluntary or ☐ Involuntary admission?

If involuntary…

	Clinician name/MD name	**Date**	**Time of signature**
CONX1:			
CONX2:			

Describe in detail the patient's current condition to include…(thorough mental status, behavioral symptoms).

Suicidal ideation? (plans/means/intent)

Homicidal ideation? (plans/means/intent)

Psychosis? ☐ Yes ☐ No

Other symptoms/concerns:
Please provide specific details of psychotic symptoms.

Is there duty to warn? ☐ Yes ☐ No
If yes, please provide details.

Describe any history of attempts with specific dates (suicidal attempts, homicidal attempts or overall aggression towards others and/or property).

Precipitant:

Treatment history with specific dates:

Describe member's baseline:

Why can the member not be treated in a lower level of care at this time?

Medications	**Dose**	**Frequency**	**Dates**	**Outcome**

Medication adherence? Barriers to adherence?

Urinary Drug Screen (UDS) and/or Blood Alcohol (BAL) results:

Fill out this section only if patient is under the age of 18.

Who has custody of member? ____________________

Is there any current CPS/DCS involvement? ☐ Yes ☐ No

Do any current symptoms/behaviors occur in school setting? ☐ Yes ☐ No

Is the school involved in current treatment plan? ☐ Yes ☐ No

Is the member involved with special education? ☐ Yes ☐ No

Fill out this section only if patient has substance abuse issues.

Note above-referenced UDS and BAL.

Drugs of choice	Amount of use	Frequency of use	Age of first use	Date of last use	Method of adminstration

Longest period of sobriety including dates: ____________________

Vital Signs:

- Blood pressure: ____________________
- Heart rate: ____________________
- Temperature: ____________________

Is there history of seizures, DT's (delirium tremens) or blackouts? ☐ Yes ☐ No

"Is the member pregnant?" ☐ Yes ☐ No
"If yes, specify duration of pregnancy." then add a text box for this information. ____________________

Current withdrawal symptoms:

Psychological and/or legal consequences of substance use:

Substance abuse treatment history including dates:

Support system involvement:

Member's triggers:

Fill out this section only if patient has eating disorder issues.

Member height: ____________________

Member weight: ____________________

% Ideal body weight (IBW): ____________________

Current BMI: ____________________

Orthostatic blood pressure: ____________________

Standing: ____________________

Sitting: ____________________

Pulse rate: ____________________

EKG, electrolytes, and other lab information:

Goal weight/BMI: ____________________

Last known episode of binging/purging/witholding: ____________________

Triggers for binging/purging/witholding: ____________________

Precipitant(s):

Fill out this section only if patient needs sexual offender related services.

Presenting problem:

What is current involvement with legal system and/or DCS?

When was the last time these behaviors occurred? ________________________________

In what setting do these behaviors occur?

Is the school setting involved in current treatment plan? ☐ Yes ☐ No

Has a psychosexual assessment been completed prior to this request? ☐ Yes ☐ No
(If yes, please attach said assessment.)

Fill out this section for concurrent review only.

What progress has been made since the last review in regards to symptoms, behaviors, diagnosis, etc?

Current suicidal/homicidal ideations or psychosis present:

Medication changes:

If no progress, how will the treatment plan be changed?

Family involvement (phone, education, family sessions, visitations), please list details:

Treatment and Discharge Planning Section

What are the individualized attainable treatment plan goals and objectives for this level of care?

Are there any limitations for family participation in treatment (transportation, non-compliance, legal, etc.)? ☐ Yes ☐ No
(If yes, please provide details.)

Discharge plan:

Anticipated barriers to discharge:

Primary care physician name and efforts to coordinate care:

Signature of ordering clinician with credentials (required to process):

___

Date of signature:___

Fax pre-certification numbers:

BlueAdvantage: 1-888-535-5243
BlueCare Plus: 1-866-325-6698
Bluecare/TennCare*Select*: 1-800-292-5311
CoverKids: 1-800-851-2491

Customer service numbers:

BlueAdvantage: 1-800-841-7434
BlueCare Plus: 1-800-299-1407
BlueCare: 1-800-468-9736
TennCare*Select*: 1-800-276-1978
CoverKids: 1-800-924-7141

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

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