Prior Authorization and Continued Stay Request Form for Residential Services

BlueCross BlueShield Arizona
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Health Choice

INSTRUCTIONS: Forms must be typed. Fax completed forms and required documents to BCBSAZ Health Choice Behavioral Health Medical Management Department. **Fax to 480-760-4732 with supporting documentation.**

- (CON)/(RON) Certificate of Need for BHIF Admission and Recertification of Need for Continued Stay Review
- Current Psychiatric/Psychosocial Evaluation
- Current ASAM Required for Members with a primary substance use disorder
- Current Treatment Plan/Goals
- Discharge Plan
- Monthly Progress Notes
- *CFT - Children Prior Authorization and Continued Stay
- Medication List
- Any other relevant clinical information
- CALOCUS

Date of Request:	

Number of days requested:	
BHIF up to 30 days **BHRF up to 60 days** **TFC up to 90 days**	

Member Information

Member Name:		**Member ID/AHCCCS ID:**	
DOB:	**Age:**	**Gender:**	**Group #:**
Health Plan:	☐ **Pathways** ☐ **Health Choice** ☐ **ACA StandardHealth with Health Choice**		
Other Health Insurance:	☐ **Yes** ☐ **No**	**Carrier:**	
Is member currently inpatient? *If inpatient, please include updated inpatient records*	☐ **Yes** ☐ **No**	**Name of Facility:**	
Current location of member: *(home, group home, ED, community, homeless, etc.) (enter location name not an address)*			

Requested Service Level:

☐	**Prior Authorization**	
☐	**Continued Stay (Authorization # required for Continued Stay requests)**	**#**

☐	**Expedited (*All BHRF/SUD BHRF requests are expedited up to 72hrs)** ***Expedited means a request for which a provider indicates, or a Contractor determines using the standard time frame for issuing an authorization decision that could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.***
☐	**Standard**

☐	**(BHIF) Behavioral Health Inpatient Facility**
☐	**(BHRF) Behavioral Health Residential Facility**
☐	**(SUD BHRF) Substance Use Disorder Behavioral Health Residential Facility (H0019)**
☐	**(ABHTH) Adult Behavioral Health Therapeutic Home**
☐	**(TFC) Therapeutic Foster Care**

Requestor Information

Name:	**Telephone:**	**Email/Fax:**
Physician Name:	**Telephone:**	**Email:**

Residential Facility Placement Information (if applicable)

Facility Name:	**Tax ID:**	**NPI:**
Contact Person:	**Telephone:**	**Email:**

Treatment Team Information (if applicable)

Behavioral Health Home/Outpatient Provider:		
Physician Name:	**Telephone:**	**Email:**
Case Manager:	**Telephone:**	**Email:**

ICD 10 Primary Diagnosis Codes and Narrative (Complete for initial and continued stay request)

1. Code:	**Narrative:**
2. Code:	**Narrative:**
3. Code:	**Narrative:**

Prior Authorization Review Clinical Information (Required for all Prior Authorization requests)

Please describe why Out-Of-Home services are being requested:

Describe in detail the severity of behavioral health and/or substance use disorder. History of trauma. Include current mental health status, *substance use type, *amount, *duration, and *last use *(please complete or attach information with form that describes substance use)*:

Self-care assessment (include ability to attend to activities of daily living, functional status in the home, school/work and social setting).

Evidence for why outpatient treatment is not successful or a safe alternative:

Current/Previous Treatment History *(Please complete or attach supporting documents)*

Dates of Treatment	Facility/Provider	Type of Treatment (include MAT if applicable)	Treatment Successful (Y/N)

Current Medications - Psychotropic and Medical (*Please complete or attach current medication list)*		
Medication	**Dosage**	**Frequency**

Children and Adolescent Section only *(Required for all C/A requests)*

Who has custody of the child (i.e., Bio parent, adoptive parent, family member)?
What does family involvement look like?
Any barriers to family involvement?
Is there any current DCS/Justice System involvement? ☐ Yes ☐ No
If yes, please describe:
Is this child currently attending school? ☐ Yes ☐ No
Do any current symptoms/behaviors occur in school setting? ☐ Yes ☐ No
If yes, please describe:
Does child have IEP? ☐ Yes ☐ No
Does child have functional behavioral health assessment? ☐ Yes ☐ No

If yes, date of last FBA:	**FBA completed by:**

Current CALOCUS is required – please attach

Discharge Planning (Required for all authorization requests)

Anticipated Discharge Plan and Needs:
Current benefits, including financial resources and amounts (e.g., SSI, SSDI, etc.):
Please provide tentative living situation and treatment that member will receive upon discharge from residential treatment:
Please describe other support resources and relationships available at home, within social networks, and coping skills necessary to achieve recovery:

Continued Stay Request Reviews Only

(Copied submissions will be considered incomplete and will require re-submission)

For continued stay, provide a narrative of the <u>current symptoms/behaviors in the last 30 days</u> that support the need for residential care:
Summarize the progress or lack of progress and justification for continued stay:
If there is no documented progress, please explain how this is being addressed:
Any medication changes from last review? ☐ **Yes** ☐ **No**
If yes, please indicate changes:

Discharge Readiness Goals (For Continued Stay requests)

Goal	Progress (Met, Not Met - Please explain)
Goal #1	
Goal #2	
Goal #3	

☐	**By checking this box, you are confirming Member/Guardian agrees with this request. Member/Guardian consent is required.**
Date prepared:	**Signature of preparer:**