Behavioral Health Inpatient Facility (BHIF), Behavioral Health Residential Facility (BHRF), Therapeutic Foster Care for Children (TFC) and Substance Use Disorder (SUD BHRF) Prior Authorization and Continued Stay Request Form

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
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**

Supporting Documentation to be included with this form

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

Date of Request:	

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

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 could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.***
☐	**Standard**

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

Requestor Information

Name:	**Telephone:**	**Email:**
Physician Name:	**Telephone:**	**Email:**

Out-of-Home Facility Placement Information

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

Treatment Team Information

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

Member Information

Member Name:		**AHCCCS ID:**	**Gender:**
		DOB:	**Age:**
Is member currently inpatient? *If inpatient, please include updated inpatient records.*	☐ **Yes**	**Name of Facility:**	
	☐ **No**		
Current location of member: *(home, group home, ED, community, homeless, etc.) (enter location <u>name</u> not an address)*			

☐ **By checking this box you are confirming Member/Guardian agrees with this request. Member/Guardian consent <u>is</u> required.**

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**

Discharge Readiness Goals (Continued Stay Request)

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

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

Who has custody of the child?	
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 Total LOCUS/CALOCUS:	

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 require re-submission)

For continued stay, provide a narrative of the current symptoms/behaviors 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, explain how this is being addressed:
Any medication changes from last review? ☐ **Yes** ☐ **No**
If yes, please indicate changes:

Date prepared:	**Signature of preparer:**

Last Revised 6/5/2023