



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

## Federal Employee Program (FEP) Outpatient Mental Health Substance Abuse Benefit Information

**Mental health and substance abuse pre-authorization highlights for FEP Standard Option and Basic Option Plan members are listed below:**

STANDARD OPTION PLAN	BASIC OPTION PLAN
Starting January 1, 2009 requires pre-authorization	Requires pre-authorization
Requires pre-authorization for each Preferred provider	Requires pre-authorization for each Preferred provider
Standard Option members have a <b>limit of 25 visits available for Non-Preferred providers</b> or for Preferred providers in the absence of pre-authorization.	Basic Option members <b>do not have coverage for Non-Preferred providers.</b>
No authorization is required for psychological testing or medication management (CPT 90862). Psychotherapy with medication management (CPT 90805 and 90807) requires treatment authorization.	Same as Standard Option
If Medicare is primary, only submit a treatment plan when Medicare benefits have been exhausted.	Same as Standard Option
Treatment authorizations are valid up to one calendar year. They do not extend beyond the end of the calendar year. Benefits renew annually.	Same as Standard Option

To verify eligibility and benefits please contact our FEP Customer Service department at 1 (877) 668-4657. A complete list of pre-authorization requirements for FEP members is located in the Care Management section of our *Provider Web Site* at **[www.ut.regence.com/physician](http://www.ut.regence.com/physician)**.

To obtain pre-authorization for outpatient mental health or substance abuse professional care, please contact Regence Behavioral Health and Wellness at 1 (866) 873-9743.

# REGENCE BEHAVIORAL HEALTH TREATMENT PLAN REQUEST FORM

Confidential Information

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  M  F  
Provider Name: \_\_\_\_\_ Provider ID/Rider #: \_\_\_\_\_  
Provider Phone #: \_\_\_\_\_ Service Address: \_\_\_\_\_  
Health/Benefit Plan:  FEP  PEBB-OR  RBCBS-OR  RBS-WA  RBCBS-UT  RBS-ID Other: \_\_\_\_\_

**I. Diagnosis: Use DSM-IV; Include all Axes**  
Axis I \_\_\_\_\_ Functional Impairments:  Job/School  Relationships/Family  Disability  
Axis II (Personality) \_\_\_\_\_  Other \_\_\_\_\_  
Axis III (Medical conditions) \_\_\_\_\_  
Axis IV (Stressors) \_\_\_\_\_  
Axis V (GAF) Current \_\_\_\_\_ Highest in the last 12 months \_\_\_\_\_

**II. Current Risk Factors: Check all that apply and explain in Presenting Symptoms section.**  
Suicidal/Homicidal Ideation: (None) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 (Severe)  Safety Plan  
Substance Abuse:  None  Remission  Unstable Remission  Abuse  Dependence  Under Evaluation

**III. Treatment Information – Current Episode**  
First date of service: \_\_\_\_\_ Number of Sessions to date: \_\_\_\_\_ Number of Sessions Requested at this time: \_\_\_\_\_  
Modality to date: Individual # \_\_\_\_\_ Family # \_\_\_\_\_ Joint # \_\_\_\_\_ Group # \_\_\_\_\_ Med Mgmt # \_\_\_\_\_  ½ Hour  1 Hour  
Modality requested: Individual # \_\_\_\_\_ Family # \_\_\_\_\_ Joint # \_\_\_\_\_ Group # \_\_\_\_\_ Med Mgmt # \_\_\_\_\_  ½ Hour  1 Hour  
Frequency to date: \_\_\_\_\_ Frequency Requested: \_\_\_\_\_  
Type of plan:  Short term focused  Long term care  Chronic care  
Orientation:  Cognitive/behavioral Systems  Psychodynamic  Supportive/problem solving  Other \_\_\_\_\_  
Identify referrals made (adjunctive therapy, community resources): \_\_\_\_\_  
Have you coordinated care with PCP?  Yes  No With other providers (or medication prescribers)?  Yes  No

**IV. Medications:**  
Previous (dosage & length of time on medication): \_\_\_\_\_  
Current (dosage & length of time on medication): \_\_\_\_\_  
Prescribed by:  PCP  PMHNP/ARNP  Psychiatrist

**Reason for Treatment/Presenting Symptoms (specify functional impairments):**  
\_\_\_\_\_  
\_\_\_\_\_

**Relevant History (personal resources, mental health treatment history, relevant new information for resubmission):**  
\_\_\_\_\_  
\_\_\_\_\_

<b>Treatment Goals (behaviorally defined):</b> _____ _____	<b>Progress made toward each goal:</b> _____ _____
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**Termination Criteria: Briefly describe termination criteria (observable, measurable, and related to symptoms):**  
\_\_\_\_\_  
\_\_\_\_\_

**Estimated Number of Sessions to Termination of Current Episode of Treatment:**  
\_\_\_\_\_

Signature: \_\_\_\_\_ Licensure: \_\_\_\_\_ Date: \_\_\_\_\_

- Fax the completed treatment plan to: Regence Behavioral Health 1 (800) 331-3505
- Or mail this request to:  
Regence BlueShield  
PO Box 21267 MS S510  
Seattle, WA 98101-3267
- For treatment plan authorization questions only, please call 1 (866) 873-9743