Regence

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

BEHAVIORAL HEALTH TREATMENT PLAN REQUEST FORM

Confidential Information – Fax completed form with cover sheet to 1 (888) 496-1540

Patient Name: ________________________________ **Patient ID:** ____________________ **DOB:** __________
Provider Name: __________________________________ **Provider NPI:** ____________________________
Provider Phone #:_______________________________ **Provider Fax #:** ____________________________
Physical/Service Address:____
Requested Start Date of Authorization: ____

I. Diagnosis: Use DSM-IV; Include all Axes
Axis I ______________________ **Functional Impairments:** ☐**Job/School** ☐**Relationships/Family**
Axis II (Personality) ____________________________ ☐**Disability** ☐**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** ☐**Under Evaluation**

III. Treatment Information – Current Episode
First Date of Service: _____________ **Number of Sessions to date:** _____________
Number of Sessions Requested at this time: _______
Frequency to date: __________________________ **Frequency Requested:** __________________________
Modality to date: 90806 # ___ 90807 # ___ 90846 # ___ 90847 # ___ 90853 # ___ 90862 # ___
Modality requested: 90806 # ___ 90807 # ___ 90846 # ___ 90847 # ___ 90853 # ___ 90862 # ___
Type of plan: ☐**Short term focused** ☐**Long term care** ☐**Chronic care**
Orientation: ☐**Cognitive/behavioral** ☐**Psychodynamic** ☐**Supportive/problem Solving** ☐**Other** _________
Identify referrals made (adjunctive therapy, community resources): _____________________________
Have you coordinated care with PCP? ☐**Yes** ☐**No** **With other providers?** ☐**Yes** ☐**No**

IV. Medications, prescribed by: ☐**PCP** ☐**PMHNP/ARNP** ☐**Psychiatrist**
Previous (dosage & length of time on medication) ____
Current (dosage & length of time on medication) ____

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

Relevant History (personal resources, mental health treatment history, relevant new information):

Treatment Goals (behaviorally defined):	**Progress made toward each goal:**

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 1 (888) 496-1540**
- **To verify benefits and eligibility, please call the number on the back of the member's card**
- **For treatment plan and authorization questions only, please call 1 (800) 787-5757**