BlueCross BlueShield of Texas

BH Post Service Review Request Form

To expedite your post service review request, please complete this entire form and include related medical records or claims submission. This completed form and related medical records are required to determine if the treatment meets the definition of medical necessity under the member's health benefit plan. To obtain eligibility and benefits use Availity® Essentials or call Customer Service at 1-800-528-7264.

Instructions: Print and fax completed form and related medical records to Blue Cross and Blue Shield of Texas at 1-877-361-7646.

Notes:

- This form is used to assist in the completion of a BH post service clinical review prior to claim payment
- BH post service clinical reviews cannot be processed until a claim has been submitted
- If a post service clinical review is requested for an Outpatient Level of Care, please locate the applicable form on our website.

Request Submission Date: _____

Patient Name: _____ Patient Date of Birth: _____

Subscriber Name: _____ Subscriber ID: _____ Group: _____

Facility Name: _____ Facility NPI: _____

Facility Address: _____ City: _____ State: _____ Zip: _____

☐ In-network Provider ☐ Out-of-network Provider

Attending Provider Name: _____ Provider NPI: _____

Facility Address: _____ City: _____ State: _____ Zip: _____

☐ In-network Provider ☐ Out-of-network Provider

1st Level of Care (LOC): _____ Revenue and/or HCPCS Code(s) Billed: _____

1st LOC Admit Date: _____ Total Days Used (#): _____ Discharge Date: _____

1st LOC Treatment days of the week (please check): ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S ☐ SU

2nd Level of Care (LOC): _____ Revenue and/or HCPCS Code(s) Billed: _____

2nd LOC Admit Date: _____ Total Days Used (#): _____ Discharge Date: _____

2nd LOC Treatment days of the week (please check): ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S ☐ SU

3rd Level of Care (LOC): _____ Revenue and/or HCPCS Code(s) Billed: _____

3rd LOC Admit Date: _____ Total Days Used (#): _____ Discharge Date: _____

3rd LOC Treatment days of the week (please check): ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S ☐ SU

If facility is OON and Residential and/or Partial Hospitalization is requested:

- Please provide a copy of your license
- If RTC, what was the on-site nursing schedule during the dates of service? _____
- If RTC, what was the on-call nursing schedule during the dates of service? _____

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Current DX — Please list ICD-10 code, diagnosis name, specifier and all medical diagnoses:

ICD-10 Code: _____ DX Name: _____ Specifier: _____

ICD-10 Code: _____ DX Name: _____ Specifier: _____

ICD-10 Code: _____ DX Name: _____ Specifier: _____

Medications (Dosages):

Clinical Presentation (Please provide information to substantiate medical necessity throughout treatment episode):

1. Mental Status at admit and throughout treatment (Substance Disorder – date of first use, pattern of use, last date of use, cravings and severity; Eating DO – include HT, WT, BMI):

2. Risk Factors at admit and throughout treatment (SI, HI, Psychosis, Medical, ADLs or current functional impairments that can't be addressed in lower Level of Care):

3. Progress toward treatment goals:

4. Discharge Plan/Summary

Please complete form in its entirety. Incomplete forms cannot be processed and will require resubmission.

Please attach relevant medical records including intake documentation, progress notes, as well as discharge clinical.

My signature confirms that I, or the facility I represent, have provided the requested services.

Signature: _____ Date: _____

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