BlueCross BlueShield of Texas

Substance Use Residential Services Request Form

This is a request to review if the service meets the medical necessity definition under the member's health benefit plan. It does not confirm the patient is eligible for benefits. For Initial Services, the Provider must call to check benefits at:

Blue Cross and Blue Shield of Texas STAR: 1-877-560-8055

Blue Cross and Blue Shield of Texas STAR Kids: 1-877-784-6802

After completing the form, please fax to **1-888-530-9809**

Date:			
Check (only) One: ☐ *Initial Request ☐ **Concurrent Request			
Member Name:		Date of Birth:	
Member ID#:		Member Phone#:	
Member Address:	City:	State:	Zip:
Legal Guardian/Power of Attorney Name:			
Legal Guardian/Power of Attorney Address:			
Provider Name:	Provider TAX ID#:		NPI:
Provider Address:			
Is the provider registered with Medicaid? ☐ Yes ☐ No			
UR/Contact Name:		Phone:	
Service Information			
Service Code Requested:	Number of Units/Days Requested:		
Member Admission Date:	Dates of Service Requested:		
Are requested services due to life-threating member emergency? ☐ Yes, Emergent/Urgent Member Symptomology Explain Clinical Reason for Emergency: ☐ No, Routine/Standard Member Symptomology Are Services Court Ordered: If yes, fax court order to fax number above.			
Current Behavioral Health Diagnoses			
Primary: Code #:	Diagnosis:	Specifier:	
Secondary: Code #:	Diagnosis:	Specifier:	
Teritiary: Code #:	Diagnosis:	Specifier:	

Medications (At Admission)		
Medication Name:	Dosage:	Frequency:
Medication Name:	Dosage:	Frequency:

Medications Changes			
Medication Name:	Dosage:	Frequency:	Date of Medication Change:
Medication Name:	Dosage:	Frequency:	Date of Medication Change:
Medication Name:	Dosage:	Frequency:	Date of Medication Change:
Medication Name:	Dosage:	Frequency:	Date of Medication Change:

Is the member adherent with medications? ☐ Yes ☐ No ☐ N/A

If No, explain barriers to medication adherence:

Medical History: *(*History - Initial Request Requirement Only)*

Clinical Presentation (within the last 48 hours)	
COWS/CIWA Scores:	**Vitals:**
UDS/BAL:	**Mental Status Exam (MSE):**

Significant Risk Factors

Has member had any of the following in the past 6 months?

Recent/Current Substance Abuse: ☐ Yes ☐ No If yes, please explain:

Psychiatric Hospitalizations: ☐ Yes ☐ No If yes, please explain:

ER Visits: ☐ Yes ☐ No If yes, please explain:

Mobile Crisis Events: ☐ Yes ☐ No If yes, please explain:

Legal Issues/Custody Orders □ Yes □ No If yes, please explain:

Current Functional Impairments *(i.e., ability to attend to ADLs, etc.):*

Current Cognitive Impairments:

Location of services being provided to member *(e.g., home, facility, etc.):*

Non Medical Drivers of Heath: (Please check all that apply)

Health and HealthCare: □ Yes □ No If yes, please explain:

Career or Educational: □ Yes □ No If yes, please explain:

Transportation Neighborhood Built Environment: □ Yes □ No If yes, please explain:

Family and Community Support: □ Yes □ No If yes, please explain:

Economic Stability: □ Yes □ No If yes, please explain:

Food Insecurity: □ Yes □ No If yes, please explain:

Safety or Environmental Hazard: □ Yes □ No If yes, please explain:

Living Situation or Utilities: □ Yes □ No If yes, please explain:

Other: Please explain:

Treatment History: ***use space below to describe treatment history.***

MEASURABLE TREATMENT GOALS
Goal #1:
Progress towards goal: *(**Concurrent Request Requirement Only)*
Anticipated progress by next review:
Goal #2:
Progress towards goal: *(**Concurrent Request Requirement Only)*
Anticipated progress by next review:
Goal #3:
Progress towards goal: *(**Concurrent Request Requirement Only)*
Anticipated progress by next review:

Goal #4:
Progress towards goal: *(**Concurrent Request Requirement Only)*
Anticipated progress by next review:

MEASURABLE TREATMENT GOALS *(continued)*

Goal #5:

Progress towards goal: *(**Concurrent Request Requirement Only)*

Anticipated progress by next review:

Additional Comments Regarding Measurable Progress: *(**Concurrent Request Requirement Only)*

Discharge/Transition to Lower Level of Care Plan

Anticipated Discharge Date:

Discharge Housing Plan

Discharge Service:

Discharge Provider:

Follow Up Appointment Date:

Plan for Medication Adherence:

(Specify the anticipated lower level of care and what barriers currently exist that prevent that member from reasonably being able to be managed at that level.)