Peer Support Form

This form should be completed at a minimum of every 12 months. This form must be completed by the service provider or their representative. The individual receiving this service must review and agree to the services documented in this request. Please complete the form and attach supporting clinical documents.

Please send the completed authorization request form with all supporting clinical documentation by:

- Availity Essentials-Provider Portal: http://apps.availity.com/web/onboarding/availity-fr-ui/#/login
- Fax: 701-277-2971
- Urgent Fax: 701-277-2138
  - Urgent definition: The absence of treatment could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or in the opinion of a health care provider with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.
- Mail: BCBSND
  Attn: Utilization Management
  4510 13th Ave S
  Fargo, ND 58121

Please fill out the form completely and do not state a reference to other documentation.

Patient Information	
Name	
Benefit plan number	Date of birth *(MM/DD/YYYY)*
Diagnosis and diagnosis code	
Name/credentials of individual who completed the diagnostic evaluation	
Parent/guardian name(s)	Contact number

Provider Information	
Date of services being requested	Date services began *(If services are in process)*
Individual Performing the Services and License Registration*	NPI number
Phone number	Fax number
Address	

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Provider Information		
City	State	Zip
Contact person *(If additional information is needed)*	Phone Number	

Initial Criteria

Please submit supporting documentation.

H0038 units _____ per 12 months

1. Does the member have a severe and persistent behavioral health condition as defined by the most recent version of the DSM and document by an independent clinician?

   ☐ Yes ☐ No

   If yes, please explain

2. Any one of the following criteria must also be documented in the request for services.

   a. The member has significant difficulty consistently and independently accessing or utilizing ambulatory behavioral health care or medical care. For example, the member relies primarily on emergency room services as evidenced by three (3) or more visit to the ER within the six (6) months or has had two (2) or more inpatient admissions in the last year.

   ☐ Yes ☐ No

   If yes, please explain

BND-23-0367946 • 9-24 URAC 12.4

Initial Criteria

Please submit supporting documentation.

b. The member is either being discharged from a hospital or a facility-based program or being released from incarceration.

☐ Yes ☐ No

If yes, please explain

c. The member has significant difficulty consistently and independently managing age-appropriate activities of daily living, including finances, hygiene, nutrition and meal preparation, home maintenance, childcare, or legal, housing, transportation, and other community service needs.

☐ Yes ☐ No

If yes, please explain

d. The member has significant difficulty obtaining or maintaining employment.

☐ Yes ☐ No

If yes, please explain

Initial Criteria

Please submit supporting documentation.

e. The member lives in an unsafe environment or impermanent housing. For example, an unsafe living environment may include abusive, enabling, living situation poses a significantly increased risk for the individual due to the uncontrolled psychiatric, substance use disorder, dangerous, or illegal behaviors (e.g., drug−dealing or sexual exploitation) of others living in the residence.

☐ Yes ☐ No

If yes, please explain

f. The member does not have family or social supports, or the family or social supports cannot or are not capable of helping the member utilize care or manage his or her behavioral health condition.

☐ Yes ☐ No

If yes, please explain

Initial Criteria

Please submit supporting documentation.

3. Any one of the following criteria must also be documented in the request for services.

   a. The member has a treatment plan that adequately addresses his or her behavioral health and co-occurring general medical conditions.

   ☐ Yes ☐ No

   If no, please explain

   b. The member is getting duplicative services from an already existing program such as 1915i.

   ☐ Yes ☐ No

   If yes, please explain

Concurrent Review
Must have ONE (1) of the following.
1. Member has seen a reduction in ER admissions and/or hospital admissions and need continued peer support to maintain progress. ☐ Yes ☐ No If yes, please explain
2. Member has made an improvement in 25% of documented age-appropriate activities noted on initial treatment plan and needs peer support to continue or maintain gains. ☐ Yes ☐ No If yes, please explain

Concurrent Review

Must have ONE (1) of the following.

3. Member has gained employment in the last three (3) months and need peer support to continue/or maintain employment.

☐ Yes ☐ No

If yes, please explain

4. Member has gained housing in the last three (3) months and needs peer support to continue and/or maintain housing.

☐ Yes ☐ No

If yes, please explain

5. New issues have been identified that requires peer support and has measurable goals are identified in the treatment plan.

☐ Yes ☐ No

If yes, please explain

Concurrent Review
6. The member has a treatment plan that adequately addresses why additional services are requested that addresses the members behavioral health and co-occurring general medical conditions. ☐ Yes ☐ No If yes, please explain
7. The member is not getting duplicative services from an already existing program such as 1915i. ☐ Yes ☐ No If yes, please explain

H0038	Peer support services are billed in 15-minutes units. Services are recommended for eight (8) hours per day (32 units daily) and 260 hours annually.	Yearly recommendation add up to 260 hours or 1040 units

BND-23-0367946 • 9-24 URAC 12.4