Psychiatric and Substance Abuse Outpatient Authorization Form

Fax to (701) 277-2253

Mail to BCBSND
Attn: Health Network Innovation
4510 13th Ave S
Fargo, ND 58121

Please complete and fax the entire form and attach appropriate clinical documents.

**PLEASE PROVIDE LAST 4 PROGRESS NOTES AND ORIGINAL INTAKE NOTE OR MOST RECENT TREATMENT PLAN

Patient Information

Patient Name: _____ Date of Birth: _____

Benefit Plan Number: _____ Provider Name: _____

NPI Number: _____ Provider Credentials: _____ Phone Number: _____

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

Contact Person if additional information is needed: _____ Phone Number: _____

Request for Continued Services through December 31st of current year

Please check all those that apply.

☐ **Individual Sessions (90832, 90834, 90837)**

Number of sessions requested for remainder of the calendar year: _____

Frequency of being seen: _____ Last date seen: _____

☐ **Group Sessions: (90853, H0005)**

Number of sessions requested for remainder of the calendar year: _____

Frequency of being seen: _____ Last date seen: _____

☐ **Psychotherapy Add-on: (90833, 90836, 90838)**

Number of sessions requested for remainder of the calendar year: _____

Frequency of being seen: _____ Last date seen: _____

☐ **Other:** _____

Rationale for this code: _____

Number of sessions requested for remainder of the calendar year: _____

Frequency of being seen: _____ Last date seen: _____

Date of initial appointment: _____ Anticipated date of the completion of treatment: _____

At the time of completing this form, the total number of sessions completed with this member for this calendar year: _____

Has a trial of decreasing frequency and/or intensity of visits been tried?: ☐ Yes ☐ No

If yes, what was the patient's response? _____

If no, why not? _____

Treatment History

Current Diagnoses: _____

Current stressors affecting treatment in the last 3 months:

_____

_____

_____

Current Risk Assessment within the last 4 weeks:

Suicidal: ☐ Ideation ☐ Plan ☐ Intent ☐ Harm to Self ☐ NA

Homicidal: ☐ Ideation ☐ Plan ☐ Intent ☐ NA

Risk Assessment within the 6 months:

Suicidal/Homicidal: ☐ Ideation ☐ Plan ☐ Intent ☐ Harm to Self ☐ NA

Is member on psychiatric medications?: ☐ Yes ☐ No

If yes, is the member compliant?: ☐ Yes ☐ No

Other Treatment

Please list all active providers/programs involved in the members care this calender year.

Active Provider / Treatment Program: _____

Communications/Coordination of care have occured within the last 6 months?: ☐ Yes ☐ No

Active Provider / Treatment Program: _____

Communications/Coordination of care have occured within the last 6 months?: ☐ Yes ☐ No

Active Provider / Treatment Program: _____

Communications/Coordination of care have occured within the last 6 months?: ☐ Yes ☐ No

Number of prior treatment episodes in the past year:

Mental Health: Inpt _____ PHP _____ RTC _____ IOP _____

Chemical Dependency: Inpt _____ PHP _____ RTC _____ IOP _____

Treatment Planning

Desired observable outcome of treatment: _____

Patient agrees with plan?: ☐ Yes ☐ No

Reminder: Please provide last 4 progress notes and original intake note or most recent treatment plan.

Provider Signature: _____ Date: _____

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