



Regence BlueShield of Idaho 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:
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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