Children's Residential Treatment Concurrent Request Form

If this is a step-down request, please use Children's Residential Treatment Initial Authorization Request Form.

Effective May 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers are required to use the Availity Essentials® Provider Portal to submit preservice prior authorization requests. **Faxes and phone calls for these requests will no longer be accepted by Blue Cross.** Please complete the clinical sections on this form and attach it to your request at Availity.com/essentials to ensure a timely review.

Providers outside of Minnesota or without electronic access can fax this form, along with clinical records to support the request. See page 4 for additional instructions.

Contact Information

Person Completing Form: ______________________________ Phone: ______________ Fax: ______________

Patient Information

Member Name: ____ Gender: ☐ M ☐ F ☐ X

Member ID: ______________________________ Date of Birth: ______________

Member Address: ____

City/state/ZIP: ______________________________________ Phone: ____________________________

Admission Information

Admission Date: ______________________________ Dates requested for this review: ______________________

Number of Days Requested: ______________________ Estimated Length of Stay: ________________________

Facility NPI / Tax ID: ____________________________ Facility Provider ID: ____________________________

Facility Name: ____

Facility Address: ____

Facility City/State/ZIP: ____

Phone: ______________________________ Fax: ______________________________

Primary Diagnosis Code: ____________________ Secondary Diagnosis Code: ________________________

Clinical Information Requested

1. What are the current treatment goals, interventions being provided, and progress towards goals?

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2. What are the acute safety concerns (behavioral incidents, restraints, seclusions, and response to interventions)?

3. What are the current symptoms that are being targeted in treatment (frequency, severity, duration)?

4. What functional impairments are present (activities of daily living, boundary concerns, academic, programming attendance and engagement, ability to follow instructions)?

5. What is the nature of the family or support system involvement (home visits, family therapy goals, community passes)?

6. Current medications and recent medication adjustments (response, adherence, side effects)?

7. What are the current barriers to discharge?

8. What is the tentative discharge timeline and plan?

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Case Management

Case Management services are available to assist the provider/member with discharge planning, family support, etc. Please contact our Behavioral Health Case Management Department at (877) 887-0873 to get connected to a case manager.

☐ **Yes**, I am interested in a case manager reaching out to assist.

Contact Name: ___________________________________Phone: _______________

☐ **No**, I am not interested at this time.

Documentation Requirements

In addition to filling out the previous pages of this form, please include documentation supporting the medical necessity of this request. Documentation should include:

- Psychiatry progress notes
- Individual therapy notes
- Family therapy notes
- Treatment plan updates from the previous week of services

Concurrent Review Guidelines

We review treatment stays regularly for medical necessity. Reviews will be done based on the patient's needs and progress.

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Providers outside of Minnesota or without electronic access can fax this form and complete clinical records to support the request, to (651) 662-0718.

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