Substance Use Disorder
Initial Authorization Request Form

BlueCross BlueShield Minnesota

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 pre-service 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 and complete clinical records to support the request, to (651) 662-0718.

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

Is this a step-down from another facility? ☐ Yes ☐ No

Is this a step-down from another level of care? ☐ Yes ☐ No

Level of Care Requested: ☐ Detox

Please select only one level ☐ High Intensity Residential

☐ Medium Intensity Residential

☐ Low Intensity Residential/Halfway House

Admission Date: _____ 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 is this patient's drug/drugs of choice? *Please include first use, last use, frequency/duration, and method/route of each substance used*

2. What are the circumstances that led to this patient's admission? *Please provide a narrative summary of the events leading to admission, precipitating event.*

3. What is the patient's treatment history? *Please include all previous treatment attempts, dates, level of care and if completed and sobriety period to follow, if any.*

4. Does the patient experience withdrawal symptoms? *If yes, what are their symptoms? Is there an increased tolerance?*

5. Is there a history of overdose? *If yes, when? Please provide specifics.*

6. Describe the need for the patient's 24-hour supervision and/or barriers preventing a lower level of care.

7. Describe any legal, financial, family, social, physical, or mental health impact to the patient.

Intake Dimension Ratings

Please provide Intake Dimension Ratings and a brief summary to support each rating. Please be specific in how ratings are determined for this patient, where patient struggles, and what goals or recommendations are being made to aid this patient in this area. Please provide specific examples, not generalized statements.

Dimension 1 – Acute Intoxication and/or Withdrawal Potential **Score:** _____

Please list any active or post-acute withdrawal symptoms or if there will be expected w/d symptoms, BAC or UDS if available, any using to the point of blacking out, etc.

Dimension 2 – Biomedical Conditions and Complications **Score:** _____

Please list any medical complications member may have, including any physical health medications

Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications **Score:** _____

Please provide an update on member's MH symptoms, including any SI/SIB/HI/Psychosis, etc.

Dimension 4 – Readiness to Change **Score:** _____

Please provide an update on motivation to change, internal/external, is member willing to follow recommendations, etc.

Dimension 5 – Relapse, Continued Use, or Continued Problem Potential **Score:** _____

Please list the relapse risks preventing a lower level of care.

Dimension 6 – Recovery/Living Environment **Score:** _____

Please provide an update if living alone or with others, if environment is supportive or use in the home, are there supportive person(s) in the home who are unable to manage member's use, driving under the influence or engagement in risky behaviors, employment, etc.).

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.

Concurrent Review Guidelines

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

Please note: A new (Initial) pre-certification request must be submitted for patients who are transitioning from one level of care to another prior to the transition.

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