



Regence BlueShield 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