Regence

Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

Confidential Information:
Fax completed form with cover sheet to 1 (888) 496-1540

BEHAVIORAL HEALTH TREATMENT PLAN REQUEST

(Please Print Legibly)

Patient Name	Patient Identification Number	Date of Birth
Provider Name	Provider NPI	
Physical/Service Address		
Provider Phone Number	Provider Fax Number	Requested Start Date of Authorization

I. Diagnosis: Use DSM-5

DX

DX (personality)

DX (medical conditions)

Psychosocial Stressors

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: ☐ Yes ☐ No

Substance Abuse: ☐ None ☐ Remission ☐ Unstable Remission ☐ Abuse ☐ Under Evaluation

Drug of Choice _____

Functional Impairments: ☐ Job/School ☐ Relationships/Family ☐ Disability ☐ Other _____

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 requested: 90791# _____ 90792# _____ 90832# _____ 90834# _____ 90837# _____ 90846# _____
90847# _____ 90853# _____ +90785# _____ 90839# _____ +90840# _____

Other Prescriber Modality requested: E/M code _____ # _____ +90833# _____ +90836# _____ +90838# _____

Type of plan: ☐ Short term focused ☐ Long term care ☐ Chronic care

Identify referrals made (adjunctive therapy, community resources) _____

Have you coordinated care with PCP? ☐ Yes ☐ No With other providers? ☐ Yes ☐ No Specify _____

IV. Medications, prescribed by:

☐ PCP ☐ PMHNP/ARNP ☐ Psychiatrist

Current (dosage & length of time on medication) _____

V. Reason for Treatment/Presenting Symptoms: Include relevant history and personal resources

Treatment Goals (behaviorally defined) and progress made toward each goal:

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) 780-7881