Empire BlueCross BlueShield

An Anthem Company

Behavioral Health Concurrent Review Fax Form

Please fax this form to [1-877-434-7578] on the last authorized day.

Today's Date:		
Contact information		
Member name:	Member ID or reference number:	Member date of birth:
Member address:		Member phone number:
Facility contact name and phone number (if changed):		Name of facility:
Facility NPI or Empire number:	Facility unit and phone number (if changed since initial review):	
Diagnosis (Document changes only)		
Axis I:		
Axis II:		
Axis III:		
Axis IV:		
Axis V:		
Risk assessment		
In the past 24 to 48 hours, has the member shown suicidal or homicidal thoughts or plans, physical aggression to self or others, or command auditory hallucinations; on close observation, drug and/or alcohol withdrawal symptoms or comorbid health concerns?		
If yes, explain:		
Lab results		
Medications List current medications and any changes with dates. Include medications for physical conditions. If medications require prior authorization, indicate how this is being addressed. Indicate as-needed [PRN] medications actually administered and when.		

Summary of nursing notes:
Summary of MD notes:
Other treatment plan changes or assessments (Include results of chemical dependency assessment, medical assessments or treatments):

For substance use disorders (primary or secondary), complete the following additional information:

Current Assessment of American Society of Addiction Medicine Patient Placement Criteria (PPC-2R)	
Dimension (Describe or give symptoms)	**Level of Severity**
Dimension I (Intoxication/withdrawal potential)	High: ☐ Medium: ☐ Low: ☐ Explanation (if other than low):
Dimension II (Biomedical conditions)	High: ☐ Medium: ☐ Low: ☐ Explanation (if other than low):
Dimension III (Emotional/behavioral/cognitive)	High: ☐ Medium: ☐ Low: ☐ Explanation (if other than low):
Dimension IV (Readiness to change)	High: ☐ Medium: ☐ Low: ☐ Explanation (if other than low):

Dimension V (Relapse/continued use potential) _____ _____ _____ _____	High: ☐ Medium: ☐ Low: ☐ Explanation (if other than low): _____ _____ _____ _____
Dimension VI (Recovery environment) _____ _____ _____ _____	High: ☐ Medium: ☐ Low: ☐ Explanation (if other than low): _____ _____ _____ _____

If any ASAM dimensions are high, how are they being addressed in treatment or discharge planning?
Response to treatment:
Involvement in treatment or discharge planning of member, family/guardian(s), outpatient providers or other identified supports:
Discharge planning (Note changes, barriers to discharge planning in these areas and plan for resolving barriers.)
Housing issues:
Psychiatry:
Therapy and/or counseling:
Medical:
Wraparound services:
Substance abuse services:

Was post-hospital discharge appointment scheduled? ☐ Yes ☐ No **Appointment date:**	
Days requested or expected length of stay from today:	
Submitted by:	**Phone number:**

Important Note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or have enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.