



This is a request to review whether treatment meets the medical necessity definition under the member's health benefit plan. It does not confirm eligibility of benefits. For Initial Services, the Provider must call BCBSOK at 800-672-2378 to check benefits.

Instructions: For Initial Services, submit completed form through iExchange® or print and fax completed form to BCBSOK at 877-361-7660.

Date \_\_\_\_\_

Check One: <input type="checkbox"/> Initial Request <input type="checkbox"/> Concurrent <input type="checkbox"/> Discharge	Check One: <input type="checkbox"/> CD <input type="checkbox"/> MH <input type="checkbox"/> ED
Patient Name _____	Patient Date of Birth _____
Subscriber Name _____	Subscriber ID _____ Group _____

Facility/Provider Name _____	NPI _____
Address _____	City _____ State _____ Zip _____
MD/Program Dir. Name _____	MD NPI _____
Address _____	City _____ State _____ Zip _____
UR/Contact Name _____	Phone _____ Ext. _____ Fax _____
Days Per Week (#) _____ Hrs Per Day (#) _____	Are the total hours per week between 9-20 hrs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sessions Requested (#) _____	Start Date of Additional Sessions Requested _____
Date Mbr Started IOP _____ Total Days Used (#) _____	IOP End Date _____
Treatment days of the week, please check.	<input type="checkbox"/> In-network provider <input type="checkbox"/> Out-of-network provider
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S	

**Current DX — Please list ICD-10 code, Diagnosis Name, Specifier and all Medical Diagnoses**

ICD-10 Code _____	DX Name _____	Specifier _____
ICD-10 Code _____	DX Name _____	Specifier _____
ICD-10 Code _____	DX Name _____	Specifier _____

**Medications (Dosages)**

1. Previous MH/CD/ED Treatment (Reason for same level of care transfer, if applicable)





2. Current Treatment Goals

3. Aftercare Plan (Provider names, telephone #, appointment date and time)

**Current Clinical Presentation**

1. Current Mental Status (Substance DO – date of first use, pattern of use, last date of use, cravings and severity; Eating DO – include HT, WT, BMI)

2. Current Risk Factors (SI, HI, Psychosis, Medical, ADLs or current functional impairments that can't be addressed in lower level of care)



3. Progress on treatment goals and barriers to progress

Please complete form in its entirety. Incomplete forms cannot be processed and will require resubmission.

**Do not send medical records.**

Additional clinical information can be attached if there is inadequate space on the form.

My signature confirms that I, or the facility I represent, will provide the requested services.

Signature \_\_\_\_\_ Date \_\_\_\_\_