

**SUBSTANCE ABUSE OUTPATIENT / INTENSIVE OP TREATMENT REQUEST FORM
FOR BLUE CROSS AND BLUE SHIELD OF KANSAS MEMBERS**

*Form Instructions: For initial review, complete section A and **ATTACH PATIENT ASSESSMENT**.
For continued stay, please complete both sections A & B.*

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Provider Info:

Name: _____ NPI# _____

Address: _____ Phone#: _____

Client Info:

Name: _____ Insured ID#: _____ DOB: _____

Axis I: _____ Axis II: _____

Admit Date: _____ TX modalities requested: individual family group IOP

Frequency of TX: ind _____ fam _____ grp _____ IOP _____

Sessions used from admit: ind ___ fam ___ grp ___ IOP ___ Est to TX completion: ind ___ fam ___ grp ___ IOP ___

Continued Stay Review Information:

Treatment Information

Requested Cert Start Date : _____

Is member compliant with treatment plan: Yes No Partial If partial, please explain below

UDS given? Yes No Results: _____ Is member attendance an issue? Yes No

Is member participating in AA/NA/CA? Yes No Has member obtained a sponsor? Yes No

Is the family/ primary support system involved in TX? Yes No none available

Medication changes (if applicable) _____

Are you coordinating care with other behavioral health care providers? Yes No refused

Are you coordinating care with the member's primary care physician? Yes No refused

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Progress to Date/ Reasons for continuing at this LOC/ Barriers to Progress or Step Down

Provider Signature

Date

**Please FAX this request to: 913-982-8176 or mail to: NDBH, PO Box 1627, Topeka, KS 66601-1627
For questions, please call: (800) 952-5906**