

Partial-Day Treatment Release Form



Some providers offer partial-day treatment program services for the treatment of psychiatric or substance abuse conditions. The member decides how the benefits will be processed. They can elect to trade their inpatient days for partial-day or have the partial-day service apply towards their outpatient benefits. Providers who have approved partial-day treatment programs have agreed to obtain a release form from the patient /member that designates what benefits should be utilized. We suggest that the form developed by Blue Cross and Blue Shield of Kansas be used in this process.

The undersigned is covered under a benefit program insured or administered by Blue Cross and Blue Shield of Kansas, Inc. By signing this release form, the undersigned designates under which benefits the partial-day psychiatric or substance abuse services will be processed.

I want to exchange inpatient psychiatric/substance abuse days for partial-day treatment.

I recognize that by signing this release form, Blue Cross and Blue Shield of Kansas, Inc. will process the partial-day psychiatric or substance abuse services received in accordance to the inpatient nervous or mental benefits as stipulated in my policy. Therefore, each day of partial-day psychiatric or substance abuse service will reduce the number of inpatient nervous or mental days available. This applies to services prescribed upon admission on ____/____/____ through this episode of care.

I want to use only outpatient psychiatric/substance abuse benefits for partial-day treatment.

I recognize that by signing this release form, Blue Cross and Blue Shield of Kansas, Inc. will process the partial-day psychiatric or substance abuse services received in accordance to the outpatient nervous or mental benefits as stipulated in my policy. I understand that only those services provided through the partial-day program which are eligible under the outpatient nervous or mental benefits of this policy will be considered for reimbursement. I also understand this applies to services prescribed upon admission on ____/____/____ through this episode of care.

Patient or Patient Representative _____ Date ____/____/____

Provider Representative _____ Date ____/____/____