BlueCross BlueShield of North Carolina

Use for Commercial Members (including State Health Plan)
Submit as an attachment via Blue E Authorization Portal or Fax to 866-987-4161

Partial Hospitalization Programs (PHP) Authorization Request

AUTHORIZATION REQUEST

Submission of this form is only a request for services and does not guarantee approval; not all Blue Cross NC plans provide benefit coverage for PHP. Incomplete forms may delay processing.

All NC Providers must provide their 5-digit Blue Cross Blue Shield of North Carolina (Blue Cross NC) provider ID# below.

Partial Hospitalization Programs (PHP) are outpatient care delivery services, which must be furnished by or under the supervision of registered or licensed personnel and under the direction of a licensed physician. Partial Hospitalization (PHP) is intended to provide treatment on an outpatient basis, does not include boarding/housing, and is intended to provide treatment interventions in a structured setting, with patients returning to their home environments or a community-based setting each day. Partial Hospitalization does not include treatment in a locked unit or restricted access setting.

Date of Request	Patient Name	Patient Date of Birth
Patient Blue Cross NC ID Number	**Patient Current Address (residence at time of service)**	**Program Network Status and Local BCBS Plan ID**

Servicing Provider Information + Address of location member will attend		Supervising Provider (if applicable)	
Provider Name		Provider Name	
Provider PPN#, Tax ID # or NPI		Provider PPN#, Tax ID # or NPI	
Street, Bldg., Suite #		Street, Bldg., Suite #	
City/State/Zip code		City/State/Zip code	
Phone #		Phone #	
Fax #		Fax #	

Current DX – Please list ICD-10 codes(s), Diagnosis Name, Specifier (if applicable)

ICD-10 Code ____________ DX Name ____ Specifier ____________________________
ICD-10 Code ____________ DX Name ____ Specifier ____________________________
ICD-10 Code ____________ DX Name ____ Specifier ____________________________

PLEASE SUBMIT COPY OF CURRENT LICENSURE FOR REVIEW WITH INITIAL REQUEST

Authorization Request type (check One)	☐ Initial Treatment Request ☐ Extension of Treatment Request. Please provide previous reference/authorization approval #: ____________
Place of Service	☐ Facility/Hospital Based ______________________________ **Blue Cross North Carolina will only reimburse for PHP in structured settings, with patients returning to their home environments or a community-based setting each day.**

Requested Treatment Start Date		Anticipated End Date	
# of days per week		# of hours per day	
Treatment Days of the Week (circle each)	M T W Th F Sa Su	Name of Supervising Psychiatrist and date of evaluation	
CPT (Procedure Code) and Units	☐ S0201 (SUD) (BCBSNC does not reimburse unbundled codes for PHP) ☐ H0035 (Psych) (BCBSNC does not reimburse unbundled codes for PHP) *Only one (1) unit for PHP on a facility claim, is allowed per date of service as these services are defined as per diem and includes all facility, professional, ancillary, and other services rendered to the member at the site.*		

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**** For Initial Authorization Requests Only ****

Approval must be obtained in advance of admission – failure to do so may result in reimbursement denial

SUD PHP requests must include:	Psychiatric PHP requests must include:
✓ Serial vital signs and withdrawal scale scores from the prior 72 hours for SUD ✓ Drug Screen and relevant Lab Results ✓ Documentation supporting the member and/or family member has been made aware of FDA approved Medication Assisted Treatments (MAT) available. The facility should document informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT treatment.	✓ Standardized scales for psychiatric service requests Treatment plans ✓ Medication review ✓ There is documentation of a safety plan including access for the member and/or family/support system to professional support outside of program hours.

Pertinent Medical History (active co-occurring conditions)	
Current Medications (dosages, duration)	☐ Please indicate if including as a separate attachment if necessary.
Scales and Assessments	

Treatment Plan	
Treatment History	**Please provide details related to prior treatment history and response, including service category type (i.e., Inpatient, Residential Treatment, Partial Hospitalization, Intensive Outpatient Program, regular outpatient therapy).** ☐ **Please indicate if including as a separate attachment if necessary.**

By signing below, I certify that I have the appropriate authority to request prior authorization and certification for the item(s) indicated on this request and that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in the patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available. Finally, I certify that I've completed this form in its entirety and I understand that an incomplete form may delay processing.

Signature: Date:

Submit this form as an attachment via the Blue E Authorization Portal with the required documentation.

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