



Promise Health Plan

### Behavioral Health Treatment Authorization Request for Medi-Cal members

<b>Behavioral Health Treatment Fax: (844) 283-3298</b>		<b>Behavioral Health Treatment Phone: (888) 297-1325</b>	
Use AuthAccel, Blue Shield of California’s online authorization system, to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection ( <a href="http://www.blueshieldca.com/provider">www.blueshieldca.com/provider</a> ) and click the Authorizations tab to get started.			
<b>Blue Shield has a 5 business day turn-around time on all Standard Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.</b>			
<b>Type of Request:</b> <input type="checkbox"/> <b>New Standard Request</b> <input type="checkbox"/> <b>Retro Request</b>			
<b>If you are submitting a Modification or Extension, check one, and complete the details below:</b>		<input type="checkbox"/> <b>Modification Request</b> <input type="checkbox"/> <b>Extension Request</b>	
Date last authorized:		Previous authorization number:	
BCBA justification for modification or extension:			
<b>Patient Information</b>			
First Name:		Last Name:	
Date of Birth (DOB):		Blue Shield Promise subscriber ID number:	
Street address:		City:	State:    ZIP code:
Home Phone:		Require interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> American Sign Language	Primary: <input type="checkbox"/> Home
Cell Phone:			<input type="checkbox"/> Cell
<b>Requesting QAS Provider</b>			
QAS Provider First Name:		QAS Provider Last Name:	
Facility Name:		Tax ID:	NPI:
Street address and suite number:		City:	State:    ZIP code:
Phone Number:		FAX:	Specialist type:
<b>Servicing/Rendering QAS Provider</b>		<b>If same as Requesting QAS Provider, check</b>	
QAS Provider First Name:		QAS Provider Last Name:	
Facility Name:		Tax ID:	NPI:
Street address and suite number:		City:	State:    ZIP code:
Phone Number:		FAX:	Specialist type:

**If you have questions, please call Blue Shield Promise Behavioral Health Treatment Program at (888) 297-1325.**

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[blueshieldca.com/promise](http://blueshieldca.com/promise)

<b>Place of service: (Check one box only):</b>							
<input type="checkbox"/>	Office	<input type="checkbox"/>	Home	<input type="checkbox"/>	Telehealth		
<input type="checkbox"/>	Community Setting	Other (please specify):					
<b>CPT/HCPC code(s):</b>							
Procedure Code	H0031	H0032	H0046	H2014	H2019	S5111	Other:
Hours							
Frequency	One Time	One Time	Month	Month	Month	Month	
<b>Requested start date of authorization:</b>							

**PATIENT CLINICAL INFORMATION**

**Please provide the following documentation:**

- Behavioral Health Treatment Plan and/or Progress Report, including:
  - A description of patient information, reason for referral, brief background information (e.g., demographics, living situation, or home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
  - The Member’s current level of need (baseline, expected behaviors the Guardian will demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, or modified (include explanation).
  - Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
  - Outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
  - Care coordination that involves the Guardian, school, state disability programs, and other programs and institutions, as applicable.
  - Clear identification of the service type, number of hours of direct service(s), observation and direction, Guardian training, support, and participation needed to achieve the goals and objectives, the frequency at which the Member’s progress is measured and reported, transition plan/criteria, crisis plan, and each individual Provider who is responsible for delivering services.

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