



Instructions: Please print and fax completed forms to BCBSTX at 877-361-7646. To speak to a Behavioral Health Outpatient Care Coordinator, call 800-528-7264.

Date _____

Initial Clinical Submission Subsequent Clinical Submission

Patient and Member Information	
Patient Name _____	Subscriber Name _____
Patient Date of Birth _____	Subscriber ID _____
	Group _____

Provider Information (Individual and/or Group)		
Provider Name _____	License _____	NPI _____
Address _____	City _____	State _____ Zip _____
Email Address _____	Phone _____	Fax _____

Current DX — Please include all ICD-10 codes and medical diagnoses that apply.

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

Is the patient on medications? No Yes If yes, list the current medications and dosages.

Describe the patient's response to medications: Poor Moderate Excellent

Patient's history of services (recent hospitalizations, PHP, IOP, OP, etc.), including dates of service.

Date provider began treating patient _____

Describe the patient's response to therapy: Poor Moderate Excellent

What active symptoms are being treated?

Has the patient been screened for substance abuse issues? No Yes

If no, explain the reason the patient was not screened for substance abuse.



Percentage of patient improvement since last review					
Please put an '✓' in one of the five spaces to the right of each area below.	0-20%	21-40%	41-60%	61-80%	81-100%
Interpersonal skills, social relationships					
Coping with life stressors					
Functioning in occupational or school settings					
Strength of support system					
Resolution of problems/symptoms					

Describe the patient's progress since the last review

Current Treatment Goal 1

Intervention for Goal 1

Current Treatment Goal 2

Intervention for Goal 2

What social supports and community resources (ex: support groups, church/synagogue/mosque, etc.) has the member accessed (currently or in the past)?

Request for Service Coverage, this review

Service Code Requests WITHOUT Add on Codes. (Examples: 90832, 90834, 90837, 90845, 90846, 90847, 90849, 90853, E & M codes)

CPT Code _____ Frequency _____ Start Date _____
 CPT Code _____ Frequency _____ Start Date _____
 CPT Code _____ Frequency _____ Start Date _____
 E&M or other Code _____ Frequency _____ Start Date _____

Service Code Requests WITH Add On Codes. (Indicate primary CPT code, and then add on code(s).

Add on Code Examples: 90785, 90833, 90836, 90838, 90840, 90863)

(1) CPT Code _____ Frequency _____ Start Date _____
 Add On Code _____ Frequency _____ Add On Code _____ Frequency _____
 (2) CPT Code _____ Frequency _____ Start Date _____
 Add On Code _____ Frequency _____ Add On Code _____ Frequency _____
 (3) CPT Code _____ Frequency _____ Start Date _____
 Add On Code _____ Frequency _____ Add On Code _____ Frequency _____

Anticipated treatment completion date _____

Additional comments

My signature confirms that I am providing the requested services

Signature _____ Date _____

