blue CALIFORNIA
PROMISE

Treatment Authorization Request	Behavioral Health Treatment
Behavioral Health Fax Number: (844) 283-3298	**Behavioral Health Phone Number:** (888) 297-1325

Use AuthAccel - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

Notice: Blue Shield of CA Promise Health Plan has a 7 Calendar 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.

☐ **New Standard Request** ☐ **Modification Request (see below)** ☐ **Retro Request**
☐ **New Urgent Request** ☐ **FBA Extension Request (see below)**

Important For Urgent Requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. ***If there is no MD signature present, the request will be processed as a Standard request.***

MD Signature REQUIRED For Urgent Requests Only:

☐ **Modification Request** **Or** ☐ **FBA Extension Requests Complete the Section Below:**

Date Last Authorized:	Previous Authorization Number:
BCBA justification for modification or extension:	

Patient Information:

First Name:	Last Name:
Date of Birth:	Blue Shield of California Promise Subscriber ID Number:
Street Address:	

City:	State:	Zip Code:

Home Phone: ☐ Primary	Require Interpreter: ☐ Yes ☐ No ☐ American Sign Language
Cell Phone: ☐ Primary	
Diagnosis:	ICD-10 Codes(s):

Requesting QAS Provider:

QAS Provider Name:	**Billing Tax ID:**	NPI:
Facility Name:	Facility Tax ID:	Facility NPI:
Street Address + Suite#:		

City:	State:	Zip Code:

Phone:	Fax:

Specialist Type:		
Contact Name and Phone Number:		
Servicing/Rendering QAS Provider: ***If same as Requesting QAS Provider, Check Here*** ☐		
QAS Provider Name:	**Billing Tax ID:**	NPI:
Facility Name:	Facility Tax ID:	Facility NPI:
Street Address + Suite#:		
City:	State:	Zip Code:
Phone:	Fax:	
Specialist Type:		
Contact Name and Phone Number:		

Place of Service: (Check all that apply):

☐	Office	☐	Home	☐	Telehealth
☐	Community Setting	☐	Other - Please Specify:		

FBA Request ONLY CPT/HCPC code(s):			**Estimated Number of Observations:**
Procedure Code	H0031	H0032	Please select what assessments may be utilized:
Hours			☐VB-MAPP ☐PEAK ☐Other:
Frequency	As Needed	As Needed	☐Vineland-3 ☐ABLLS-R
			☐AFLS ☐Socially Savvy

Requested Start Date of Authorization:

Direct Service Request ONLY CPT/HCPC codes(s):

Procedure Code	H0031	H0032	H0046	H2014	H2019	S5111
Hours						
Frequency	As Needed	As Needed	Month	Month	Month	Month

Requested Start Date of Authorization:

Please enter below all OTHER codes requested; unlisted codes must have a description.
Include the quantity for each code requested

ICD-10 Codes(s):
CPT/HCPC Code(s):

For questions: Call Blue Shield of CA Promise Health Plan Behavioral Health Treatment Program at (888) 297-1325

distribute it. If you are not the intended recipient, or if you have received this transmission in error, please notify the sender immediately and **confidentially** destroy the information that faxed in error. Thank you for your help in maintaining appropriate confidentiality.

Please include the documentation listed below when you return this form to Blue Shield of California Promise Health Plan:

- ☐ History and physical and/or consultation notes, including:
  - ☐ Documentation of the type and degree of behaviors needing treatment (including frequency of baseline behaviors)
  - ☐ Functional assessment
  - ☐ Clinical findings (i.e., pertinent symptoms and duration)
  - ☐ Comorbidities
  - ☐ Activity and functional limitations
  - ☐ Family history, if applicable
  - ☐ Past and present diagnostic testing and results
- ☐ Proposed/current treatment plan including but not limited to the anticipated response to treatment, goals (date of introduction, estimated date of mastery) and other types of treatment that have been tried (with results) or considered but excluded)
- ☐ For continuation, documented progress/improvement (if applicable) but not having yet met goals; why gains cannot be maintained with a lower level of care; and that treatment has not worsened issues
- ☐ 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
- ☐ Copy of the most current individualized education program (IEP)/intervention support program (ISP) (if applicable)
- ☐ Documentation of enrollment with local Regional Center
- ☐ Discharge summary from earlier treatment (if applicable/available)
- ☐ Other pertinent multidisciplinary notes/reports: (i.e., psychological or psychiatric evaluation, physical therapy, speech therapy, occupational therapy, multidisciplinary pain management), when applicable
- ☐ Results/reports of tests performed
- ☐ Procedure report(s)
- ☐ All multidisciplinary treatment notes documenting dates performed and hours spent