

Behavioral Health Care Length of Stay Extension

Request for Length of Stay Extension for Inpatient or Residential Treatment Level of Care

*Submission of this form is only a request for services and does not guarantee approval. 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.*

Date of Request	Patient Name	Patient Blue Cross NC ID Number	Patient Date of Birth

Facility UR/DC Planner Contact	Phone #	Fax #

Current Authorization Reference #	
Facility Name	
Admitting/Ordering Provider Name	

For Length of Stay Extension Requests Only <b style="color: red;">Please supply only CURRENT clinical information and send in complete Discharge Summary upon discharge <b style="color: red;">**For patient's transitioning from Inpatient to Residential, a separate authorization is required**			
Current Level of Care (please check one)	Inpatient Care	Residential Treatment Care	
	☐ Psychiatric ☐ Eating Disorder ☐ Substance Use Disorder	☐ Psychiatric ☐ Eating Disorder ☐ Substance Use Disorder	
Last Authorized Day		Additional Days Requested	
Clinical rationale and treatment plan for continued admission at this level of care:	Documentation should include the proposed treatment plan interventions and goals including changes since last review; rationale/benefits of continued care at current level versus a less intensive level of care (i.e. outpatient treatment); progress or lack thereof; and expected patient participation or commitment status		

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Patient risk or severity of behavioral health disorder; please check all applicable reasons and document clinical findings:	Does the patient currently require, or is the patient anticipated to require physical restraint or seclusion? ☐ YES ☐ NO ☐ Imminent danger to SELF – include details of current thoughts/actions for suicide attempt and/or self-harm; current intent, plans, and/or means for suicide attempt or self-harm; current risk factors for completing suicide attempt and/or self-harm ☐ Imminent danger to OTHERS – include details of current thoughts/actions for harm to others; current intent, plans, and/or means for harm to others; current risk factors for completing harm to others ☐ Inability to care for self – include description of missed work/school obligations; inability to attend to activities of daily living; changes in weight, hygiene; etc.:
Current Medications (Dosages, duration, adjustments)	
Current psychological therapy/ies being provided (type, frequency)	
Any new diagnoses being addressed	
Anticipated Discharge Plan	Include plans for transition to next level of care, when this will likely occur and where/with whom treatment will be. Explain any delays/changes in plan since last review. ☐ Please indicate if attaching a separate Discharge Summary (if already discharged)
Support System at Discharge	Include resources and relationships available at home and within social networks, and coping skills:

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Barriers to Discharge	Identify any barriers to discharge: A Blue Cross NC Case Manager is available to make outreach while the member is still admitted at your facility to assist with discharge planning and transition of care. Please provide a phone number and ideal time for the Case Manager to speak with member.																																				
Withdrawal Assessment (only complete this box for Substance Use Disorder Admissions at Inpatient and RTC)	Does the patient require around-the-clock medical or nursing monitoring for treatment of withdrawal or other medical conditions? ☐ YES ☐ NO Current ASAM Score (Please put N/A if not applicable): _____ Please include serial Vital Signs and Withdrawal Assessment Scores (COWS/CIWA/BAWS) Please indicate if including as a separate attachment if necessary. <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 25%;">Date</td><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td></tr> <tr> <td>Time</td><td></td><td></td><td></td></tr> <tr> <td>Heart Rate</td><td></td><td></td><td></td></tr> <tr> <td>Blood Pressure</td><td></td><td></td><td></td></tr> <tr> <td>Temperature</td><td></td><td></td><td></td></tr> <tr> <td> Please check W/D assessment criteria used and indicate Score ☐ CIWA ☐ COWS ☐ BAWS </td><td></td><td></td><td></td></tr> <tr> <td>Symptoms & Severity</td><td></td><td></td><td></td></tr> <tr> <td>Pertinent Labs</td><td></td><td></td><td></td></tr> <tr> <td>IBW/BMI/Weight</td><td></td><td></td><td></td></tr> </table>	Date				Time				Heart Rate				Blood Pressure				Temperature				Please check W/D assessment criteria used and indicate Score ☐ CIWA ☐ COWS ☐ BAWS				Symptoms & Severity				Pertinent Labs				IBW/BMI/Weight			
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By signing below, I certify that I have 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: _____

Fax this form with required documentation to Blue Cross NC Commercial Behavioral Health @ 866-987-4159.

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