BlueCross BlueShield of Illinois

Rule 132 Service Request Form

This is a request to review if the treatment meets the medical necessity definition under the member's health benefit plan. It does not confirm the patient is eligible for benefits. For Initial Services, the Provider must call BCBSIL at to check benefits:

MLTSS: 866-962-9814 FHP: 877-860-2837 ICP: 888-657-1211 MMAI: 877-723-7702

After completing the form, please fax to **312-233-4099**.

Date:					
Check (only) One: ☐ *Initial Request ☐ **Concurrent Request					
Check (only) One ☐ Assertive Community Treatment ☐ Community Support Team ☐ Psychosocial Rehabilitation ☐ Community Support Residential					
Subscriber Name:		Date of Birth:			
Subscriber ID#:					
Address:	City:		State:	Zip:	
Provider Name:	Provider Address:			NPI:	
Is the provider registered with the IMPACT system? ☐ Yes ☐ No					
(All providers not registered with the IMPACT system, must call customer service for authorization)					
UR/Contact Name:		Phone:			
Service Code Requested:		Number of Units Requested:			
Date Member Started Services:	Total Units Utilized:		Start Date of Request:		
Frequency, Duration and Intensity of Services *(time spent with Member per week)*:					
Current Behavioral Health Diagnoses:					
Primary: Code #:	Diagnosis:		Specifier:		
Secondary Code #:	Diagnosis:		Specifier:		
Tertiary Code #:	Diagnosis:		Specifier:		
Additional Diagnoses:					
Medications (Dosage and Frequency):					
Historical/Current Medical Issues: (*History- Initial Request Requirement Only)					
Current Psychiatric Risk Factors:					

Current Clinical Presentation ***(summary detailing why the member is meeting medical necessity – e.g., progress towards goals, areas for improvement, current functional impairment)*****:**

Location of services being provided to member ***(e.g., home, facility, etc.)*****:**

Mental Health/Chemical Dependency Treatment History ***(Treatment prior to this level of care – facilities, providers, dates of service)*****: (*History- Initial Request Requirement Only)**

MEASURABLE TREATMENT GOALS

Goal #1:

Progress towards goal: (Concurrent Request Requirement Only)**

Anticipated progress by next review:

Goal #2:

Progress towards goal: (Concurrent Request Requirement Only)**

Anticipated progress by next review:

MEASURABLE TREATMENT GOALS cont.

Goal #3:

Progress towards goal: (Concurrent Request Requirement Only)**

Anticipated progress by next review:

Goal #4:

Progress towards goal: (Concurrent Request Requirement Only)**

Anticipated progress by next review:

Goal #5:

Progress towards goal: (Concurrent Request Requirement Only)**

Anticipated progress by next review:

Additional Comments Regarding Measurable Progress: (Concurrent Request Requirement Only)**

MEASURABLE TREATMENT GOALS cont.

Discharge/Transition to Lower Level of Care Plan (Specify the anticipated lower level of care and what barriers currently exist that prevent that member from reasonably being able to be managed at that level.)

All clinical information must be received for authorization determination. Please confirm the following are included in your submission:

Documents Included in Fax Transmission	**Check If Included**
Mental Health Assessment *(Updated within one year)*	☐
Crisis Plan Completed *(Updated within one year)*	☐
Individual Treatment Plan *(Updated within six months)*	☐
LOCUS/Composite Score *(Updated within six months)*	☐

My signature confirms that I, or the facility I represent, will provide the requested services.

Signature:	Title:
Date:	

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