



This is a request to review whether treatment meets the medical necessity definition under the member's health benefit plan. It does not confirm eligibility of benefits. For initial services, providers must call Blue Cross and Blue Shield of New Mexico (BCBSNM) at 888-898-0070 to check benefits.

Instructions: For initial services, complete this form, print and fax to BCBSNM at 877-361-7659, or access the Availity® Essentials Authorizations tool and submit online.

Date _____

Check One: <input type="checkbox"/> Initial Request <input type="checkbox"/> Concurrent <input type="checkbox"/> Discharge	Check One: <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Mental Health <input type="checkbox"/> Eating Disorder
Patient Name _____	Patient Date of Birth _____
Subscriber Name _____	Subscriber ID _____ Group _____

Facility/Provider Name _____	NPI _____
Address _____	City _____ State _____ Zip _____
MD/Program Director Name _____	MD NPI _____
Address _____	City _____ State _____ Zip _____
Utilization Reviewer/Contact Name _____	Phone _____ Ext. _____ Fax _____
Days per week (#) _____ Hours per day (#) _____	Are the total hours per week between 9-20 hrs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sessions requested (#) _____	Start date of additional sessions requested _____
Date member started IOP _____ Total days used (#) _____	IOP end date _____
Please check treatment days of the week:	<input type="checkbox"/> In-network provider <input type="checkbox"/> Out-of-network provider
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SAT <input type="checkbox"/> SUN	

Current DX — List ICD-10 code, diagnosis name, specifier and all medical diagnoses

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

Medications (Dosages)

1. Previous treatment for mental health, chemical dependency or eating disorder (reason for same level of care transfer, if applicable)





2. Current treatment goals

3. Aftercare plan (provider names, telephone #, appointment date and time)

Current Clinical Presentation

1. Current mental status (substance disorder – date of first use, pattern of use, last date of use, cravings and severity; eating disorder – include height, weight, BMI)

2. Current risk factors (suicidal ideation, homicidal ideation, psychosis, medical, ADLs or current functional impairments that can't be addressed in lower level of care)



3. Progress on treatment goals and barriers to progress

Please complete form in its entirety. Incomplete forms can't be processed and will require resubmission.

Do not send medical records.

Additional clinical information can be attached if there is inadequate space on the form.

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

Signature _____ Date _____