Health Options
Highmark Blue Cross Blue Shield Delaware

Outpatient Authorization Request Form
Fax to: 1-855-412-7997

Writing that is not legible or incomplete information will potentially delay review.

Member’s Name	
Member’s Gateway ID Number	
Member’s Date of Birth	
Facility Name	
Person Completing Form	
Telephone Number	
Treating Physician/Clinician	
Date of Admission or Start of Care Under Current Plan	

Type of Outpatient Request: [ ] Mental Health [ ] Substance Abuse
[ ] continued stay [ ] step down

Is requestor a participating in network provider? Y/N

If no, provide address, phone number, and facility/Practitioner NPI

If not an in-network provider, does member have prior or existing treatment relationship with provider? Y/N

Provide summary of member’s treatment relationship with provider including summarizing why member’s care cannot be met by an in-network provider

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Page 2- Outpatient Authorization Request Form

Member Name: ____

Diagnosis/Conditions/Presenting Symptoms/Problems (include Diagnostic Code AND Diagnostic Name):

Current Psychotropic Medications (attach supplemental sheet if needed)

Medication	Dosage	Frequency

Type of Outpatient Service Requested (Complete Only for the Requested Service and Appropriate Service Line)

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Page 3- Outpatient Authorization Request Form

Member Name: ____

Behavioral Health (Only Complete this Section if Requesting Behavioral Health Services)

Partial Hospitalization (PHP)	Intensive Outpatient (IOP)	Psychological Testing	Outpatient ECT	Non- Par Authorization Request
# of Days: Hours per Day:	# Days per Week: Hours per Day:	CPT Code(s): # of hours:	# of Sessions: Frequency:	CPT Code(s) Requested: Frequency:

Substance Abuse Services (Only Complete this Section if Requesting Behavioral Health Services):

Partial Hospitalization (PHP)	Intensive Outpatient (IOP)	Halfway House	Non Par Outpatient
# of Days: Hours per Day:	# Days per Week: Hours per Day:	# of Days:	CPT Codes Requested: Frequency:

Current Withdrawal Symptoms (Complete Only for Substance Abuse Requests)

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Page 4 – Outpatient Authorization Request Form

Member Name: ____

Substance Use History (Complete Only for Substance Abuse Requests)

Substance Use Treatment History/Longest Clean Time (Complete Only for Substance Abuse Requests)

ASAM (Complete Only for Substance Abuse Requests)

ASAM Level of Care:
DIMENSION I:
DIMENSION II:
DIMENSION III:
DIMENSION IV:
DIMENSION V:
DIMENSION VI:

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Page 5 – Outpatient Authorization Request From

Member Name: ____

Discharge Planning/Transition Plan to Lower Level of Care (Complete for all requests):

Current Case Management Needs of Member (Complete for all requests):

Can member be managed at a lower Level of Care: Y/N

Explain: