Health Options
Highmark Blue Cross Blue Shield Delaware

Behavioral Health (Substance Abuse) Authorization Request Form
Fax to: 1-855-412-7997

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

Member Name	
Member's Gateway ID Number	
Member's Date of Birth	
Facility Name	
Person Completing Form	
Telephone Number	
Contact Person at Facility	
Contact Person's Phone Number	
Date of Admission or Start of Care	
Admitting Physician	
Requested ASAM Level of Care	

Circle One: **ADMISSION** **CONTINUED STAY**

Is member under the influence of drugs or alcohol at time of admission?

□ **Yes** □ **No**

Presenting Problem

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Member Name: _____

Clinical Information (Current Withdrawal Symptoms / Vital Signs / WAS / COWS)

Drug Screen Results

Is This a Readmission? □ **Yes** □ **No**

List All Diagnoses

Substance Use History (Amount, Duration, Frequency, Last Use)

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Member Name: _____

Current Medications

Medication	Dosage	Frequency

Prior Substance Use Treatment History (Facility, Dates, Clean Time)

ASAM Criteria

	Level of Care	Criteria Indicated / Risk Level
DIMENSION I:		
DIMENSION II:		
DIMENSION III:		
DIMENSION IV:		
DIMENSION V:		
DIMENSION VI:		

Treatment Plan and Orders with this Admission / Number of Days Requested

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Member Name: _____

Potential Barriers to Discharge / Stressors

Does Member Have Family/Informal Supports □ **Yes** □ **No**

List:
