BlueCross BlueShield of Oklahoma

FOCUSED OUTPATIENT MANAGEMENT PROGRAM

Clinical Update Request

Instructions: Please fill out and print, or print form and fill out legibly in black ink. Fax to BCBSOK at 877-361-7660.
To speak to a Behavioral Health Outpatient Care Coordinator, call 800-672-2378.

Date_____ ☐ Initial Clinical Submission ☐ Subsequent Clinical Submission

Patient and Member Information

Patient Name_____ Subscriber Name_____
Date of Birth_____ Subscriber ID #_____
Group #_____

Provider Information (Individual and/or Group)

Provider Name_____ License_____ NPI #_____
Address_____ City_____ State_____ Zip_____
Email Address_____ Phone #_____ Fax #_____

Current DX — Please include all DSM 5 and/or medical diagnoses that apply.

Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____
Code #: _____ DX Name: _____ Specifier: _____

Is the member on medications? ☐ No ☐ Yes If yes, what are current medications/dosages?

What has been the response to medications? ☐ Poor ☐ Moderate ☐ Excellent _____

History of Services with Dates (Recent hospitalizations, PHP, IOP, OP, etc.):

Member began treatment with you on what date? _____

What has response been to therapy? ☐ Poor ☐ Moderate ☐ Excellent

What are the current active symptoms being treated?

Has the member been screened for substance abuse issues? ☐ No ☐ Yes

If yes, please give details of substance abuse (type of drug, duration of use, last use, episodes of treatment).

If no substance abuse screening, then why?

C U R

Functioning Levels: How has the member been doing over the last 3-4 weeks?					
Please put an '✓' in one of the five spaces to the right of each area below.	Very Poor	Poor	Fair	Good	Very Good
Interpersonal Skills, Social Relationships					
Coping with Life Stressors					
Functioning in Occupational or School Settings					
Strength of Support System					
Resolution of Problems/Symptoms					

What progress has the member achieved since the last review?

Current Treatment Goal #1:

Intervention for Goal #1:

Current Treatment Goal #2:

Intervention tor Goal #2:

What social supports and community resources (ex: support groups, church/synagogue/mosque, etc.) has the member accessed (currently or in the past)?

Request for Service Coverage, this review:

Service Code Requests **WITHOUT** Add on Codes. (Examples: 90832, 90834, 90837, 90845, 90846, 90847, 90849, 90853, E & M codes)

CPT Code: _____ Frequency: _____ Start Date: _____
CPT Code: _____ Frequency: _____ Start Date: _____
CPT Code: _____ Frequency: _____ Start Date: _____
E&M or other Code: _____ Frequency: _____ Start Date: _____

Service Code Requests **WITH** Add On Codes. (Indicate primary CPT code, and then add on code(s). Add on Code Examples: 90785, 90833, 90836, 90838,90840, 90863)

(1)CPT Code#: _____ Frequency: _____ Start Date: _____
Add On Code #: _____ Frequency: _____ Add On Code #: _____ Frequency: _____
(2)CPT Code#: _____ Frequency: _____ Start Date: _____
Add On Code #: _____ Frequency: _____ Add On Code #: _____ Frequency: _____
(3)CPT Code#: _____ Frequency: _____ Start Date: _____
Add On Code #: _____ Frequency: _____ Add On Code #: _____ Frequency: _____

Anticipated Treatment Completion date:

Additional comments:

My signature confirms that I am providing the requested services:

Signature _____ Date _____

72690.0915

C U R