

**FEDERAL EMPLOYEE PROGRAM  
OUTPATIENT MENTAL HEALTH  
TREATMENT PLAN**

This form is **only** for members with **FEP primary coverage**. It is **not** for other Regence BlueCross BlueShield of Oregon plans. It is not necessary to submit this form for members with FEP secondary coverage, such as Medicare, unless primary benefits have been exhausted, services are not covered, or have been denied by the primary carrier.

The provider must call FEP Customer Service, **1 (800) 962-2731**, *before treatment begins* to verify the type of coverage, benefits, eligibility, co-payments, and deductible.

**Note: There are two types of FEP health plans. The authorization procedures differ:**

<b>STANDARD PLAN</b>	<b>BASIC PLAN</b>
A treatment plan is due after the first 8 sessions in this calendar year and before the 9 <sup>th</sup> session. <b>The initial 8 sessions are cumulative between providers. Retroactive authorization is not allowed.</b>	The 1 <sup>st</sup> treatment session must be pre-authorized via phone by the member or provider. A treatment plan is then due after the 1 <sup>st</sup> session and before additional sessions are completed. <b>Retroactive authorization is not allowed.</b>
No authorization is required for psychological testing or medication management (CPT 90862). Psychotherapy with medication management (CPT 90805 and 90807) requires treatment authorization.	No authorization is required for psychological testing or medication management (CPT 90862). Psychotherapy with medication management (CPT 90805 and 90807) <b>requires</b> treatment authorization.
If Medicare is primary, only submit a treatment plan when Medicare benefits have been exhausted.	If Medicare is primary, only call for pre-authorization when Medicare benefits have been exhausted.
Treatment authorizations are valid up to 1 calendar year. They do not extend beyond the end of the calendar year. Benefits renew annually.	Treatment authorizations are valid up to 1 calendar year. They do not extend beyond the end of the calendar year. Benefits renew annually.

Each mental health provider treating the member must submit a separate Treatment Plan. Authorizations are cumulative. Please coordinate care with other providers.

**Mail this request to: Regence BlueShield  
PO Box 21267, Mail Stop S510  
Seattle, WA 98111-3267**

**FAX this form to: 1 (800) 331-3505**

**For treatment plan authorization questions only please call: 1 (866) 873-9743.**

# REGENCE BEHAVIORAL HEALTH TREATMENT PLAN REQUEST FORM

Confidential Information

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M / F  
Provider Name: \_\_\_\_\_ Provider ID/Rider #: \_\_\_\_\_  
Provider Phone #: \_\_\_\_\_ Service Address: \_\_\_\_\_  
Health/Benefit Plan: FEP RBCBS-OR RBS-WA RBCBS-UT RBS-ID Other: \_\_\_\_\_

## I. Diagnosis: Use DSM-IV; Include all Axes

Axis I \_\_\_\_\_ Functional Impairments: Job/School Relationships/Family Disability  
Axis II (Personality) \_\_\_\_\_ Other \_\_\_\_\_  
Axis III (Medical conditions) \_\_\_\_\_  
Axis IV (Stressors) \_\_\_\_\_  
Axis V (GAF) Current \_\_\_\_\_ Highest in the last 12 months \_\_\_\_\_

## II. Current Risk Factors: Check all that apply and explain in Presenting Symptoms section.

Suicidal/Homicidal Ideation: (None) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 (Severe) Safety Plan  
Substance Abuse: None Remission Unstable Remission Abuse Dependence Under Evaluation

## III. Treatment Information – Current Episode

First date of service: \_\_\_\_\_ Number of Sessions to date: \_\_\_\_\_ Number of Sessions Requested at this time: \_\_\_\_\_  
Modality to date: Individual # \_\_\_\_\_ Family # \_\_\_\_\_ Joint # \_\_\_\_\_ Group # \_\_\_\_\_ Med Mngmt # \_\_\_\_\_ ½ Hour 1 Hour  
Modality requested: Individual # \_\_\_\_\_ Family # \_\_\_\_\_ Joint # \_\_\_\_\_ Group # \_\_\_\_\_ Med Mngmt # \_\_\_\_\_ ½ Hour 1 Hour  
Frequency to date: \_\_\_\_\_ Frequency Requested: \_\_\_\_\_  
Type of plan: Short term focused Long term care Chronic care  
Orientation: Cognitive/behavioral Systems Psychodynamic Supportive/problem solving Other \_\_\_\_\_  
Identify referrals made (adjunctive therapy, community resources): \_\_\_\_\_  
Have you coordinated care with PCP? Yes No With other providers (or medication prescribers)? Yes No

## IV. Medications:

Previous (dosage & length of time on medication): \_\_\_\_\_  
Current (dosage & length of time on medication): \_\_\_\_\_  
Prescribed by: PCP PMHNP/ARNP Psychiatrist

## Reason for Treatment/Presenting Symptoms (specify functional impairments):

## Relevant History (personal resources, mental health treatment history, relevant new information for resubmission):

## Treatment Goals (behaviorally defined):

## Progress made toward each goal:

## Termination Criteria: Briefly describe termination criteria (observable, measurable, and related to symptoms):

## Estimated Number of Sessions to Termination of Current Episode of Treatment:

Signature: \_\_\_\_\_ Licensure: \_\_\_\_\_ Date: \_\_\_\_\_

- Fax the completed treatment plan to: Regence Behavioral Health 1 (800) 331-3505
- Or mail this request to: Regence BlueShield  
PO Box 21267, Mail Stop S510  
Seattle, WA98111-3267
- For treatment plan authorization questions only, please call 1 (800) 547-9718