Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

BCN Behavioral Health IP/PHP/IOP Concurrent Review Form

Noncontracted providers: Fax the completed form to 1-877-706-1993 by 3 p.m. on the date of review. Call 1-800-482-5982 with questions.

Member number:	Member name:	Review date:
Facility name:	Reviewer's name: Reviewer's phone number:	☐ MH ☐ SA

A Services and communication with primary care practitioner

Level of care: ☐ IP ☐ PHP ☐ IOP Date of admission:

For PHP and IOP, number of days member attended since last review:

Attending psychiatrist / Last name: First name:

Primary care practitioner / Last name: First name:

PCP release of information:	☐ Offered / signed Date:
	☐ Offered / declined Date:

Date(s) PCP communication occurred:

B Member's legal status

Legal status: ☐ Voluntary ☐ Involuntary If involuntary: ☐ Deferred ☐ Court / date: _____

Does member have: ☐ Guardian ☐ Durable power of attorney ☐ N/A

Contact information for guardian / DPOA (if applicable):

C Justification for continued stay

Acute suicidal ideation with plan / intent (in past 24 hours): ☐ N/A or details:

Acute homicidal ideation with plan / intent (in past 24 hours): ☐ N/A or details:

Acute psychosis (in past 24 hours): ☐ N/A or description:

Acute detox symptoms (in past 24 hours): ☐ N/A or description:

Current DSM-5 diagnosis: (Record diagnosis code(s) and description(s); related medical concerns; other psychosocial / contextual factors.)

Signs / symptoms of acute risk factors:

Additional psychosocial / treatment history:

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D Treatment

Medications / Names and dosages of ALL (psychiatric and nonpsychiatric) medications:

Describe member's response to milieu treatment:

Additional information:

E Discharge

Anticipated d/c date:	Additional days requested:

Discharge plan:

Barriers to discharge: Check any issue listed below that is a barrier.

☐ Housing ☐ Poor supports ☐ Transportation issues ☐ Noncompliance w/ tx
☐ Job jeopardy ☐ Safety plan ☐ Lack of family involvement
☐ Other:

Follow-up appointments:

Provider type	Provider name	Telephone no.	Date	Time
Therapist/program:				
Psychiatrist:				

Note: The first follow-up appointment must be scheduled for within seven days of discharge.

If the appointment is scheduled for more than seven days after discharge, explain why: