BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

BEHAVIORAL HEALTH/SUBSTANCE ABUSE CONTINUED STAY REVIEW FORM

Patient Information

Patient Name

Contract Number (Including prefix)

Date of Review

Date of Admission

Physician Information

Physician Name

Tax ID Number

E-mail

Telephone Number

Fax Number

Contact Name

E-mail

Telephone Number

Fax Number

Hospital Information

Hospital Name

Tax ID Number

Contact Name

E-mail

Telephone Number

Fax Number

Areas of Assessment

Factors justifying need for continued care

Medication changes/PRN

Measurable Treatment Goal/Plan

Specific Discharge Plans

Anticipated Discharge Date

Fax the signed and completed form to: 1-816-237-2397.

I certify this information is complete and correct to the best of my knowledge.

Signature

Title

Date

(Rev. 02/2014)