BlueShield of Northeastern New York

Behavioral Health Criteria Set Request Form
Fax: 813-960-2492

*****Please type or write legibly or request will be returned as unable to process*****

Date of request: _____

Member: _____ Provider name/credential: _____ Provider telephone: _____

Member DOB: _____ Member age: _____ Provider fax: _____

Member ID: _____ Service address: _____ City/State/Zip: _____

Provider ID/NPI: _____ Tax ID: _____

Type of Service

Please select one:	Please select one:
☐ Mental health	☐ Member has not received services yet (Pre-service)
☐ Substance use	☐ Member is currently receiving services (Concurrent)
☐ Applied behavior analysis (ABA)	

Level of Care

☐ Inpatient (IP) mental health	☐ IP detox	☐ Outpatient (OP)
☐ Residential treatment (RTC)	☐ Partial hospitalization (PHP)	☐ Community day treatment (CDT)
☐ IP rehab	☐ Intensive outpatient (IOP)	☐ Personalized recovery oriented services (PROS)
		☐ Other:

Reason for Request:

Person to receive criteria set:

Name:

Relationship to member receiving services:

Phone number:

Address:

Please provide information for your preferred method of receiving the criteria set:

Fax:	Email:	Mail: