BlueCross BlueShield of Oklahoma

THERAPEUTIC BEHAVIORAL ON-SITE SERVICES REQUEST FORM

Therapeutic Behavioral On-Site Services Request

Provider must call BCBSOK 800-672-2378 to verify benefits. To expedite the processing of your request, please complete all sections of the form. Please fax to BCBSOK at 877-361-7660.

Therapeutic Behavioral On-Site Services involve Community Based Services that are often billed as H codes or T codes (in this format: H#### or T####).

This is not a level of care that requires prior authorization, however, in order for us to verify the services you are billing and adjudicate your claim(s) we need this form filled out in its entirety.

Note: If this is a request for Retro or Post Service Clinical Review, it cannot be processed until providers have submitted a claim.

Member Name _____ **Member Date of Birth** _____

Subscriber Name _____ **Subscriber ID** _____ **Group** _____

Facility/Billing Provider Name _____ **NPI** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Rendering Provider Name _____ **NPI** _____

Rendering Provider License Type _____ **License Number** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Start Date of Therapeutic Behavioral On-Site Services _____ **Diagnosis Code(s):** _____

1. Requested CPT/HCPCS code _____ **Dates of service: From** _____ **to** _____

Number of units of this code billed within this time frame _____

A description of the physical service the member is receiving for this CPT/HCPCS code being billed
(i.e. counseling services, assessment, treatment planning, training/education, etc.)

_____
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_____

Duration of time for 1 unit *(if applicable)*	**Treatment Location**	**Attendance Type**	**Treatment Type**
☐ **15 min**	☐ **Home**	☐ **Individual**	☐ **Assessment**
☐ **30 min**	☐ **Clinic**	☐ **Family**	☐ **Therapy**
☐ **45 min**	☐ **School**	☐ **Group**	☐ **Skills Training**
☐ **60 min**	☐ **Other** _____	☐ **Other** _____	☐ **Other** _____
☐ **Other** _____			

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BlueCross BlueShield of Oklahoma

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2. Requested CPT/HCPCS code _____ **Dates of service: From** _____ **to** _____

Number of units of this code billed within this time frame _____

A description of the physical service the member is receiving for this CPT/HCPCS code being billed
(i.e. counseling services, assessment, treatment planning, training/education, etc.)

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Duration of time for 1 unit *(if applicable)*	Treatment Location	Attendance Type	Treatment Type
☐ 15 min	☐ Home	☐ Individual	☐ Assessment
☐ 30 min	☐ Clinic	☐ Family	☐ Therapy
☐ 45 min	☐ School	☐ Group	☐ Skills Training
☐ 60 min	☐ Other _____	☐ Other _____	☐ Other _____
☐ Other _____			

3. Requested CPT/HCPCS code _____ **Dates of service: From** _____ **to** _____

Number of units of this code billed within this time frame _____

A description of the physical service the member is receiving for this CPT/HCPCS code being billed
(i.e. counseling services, assessment, treatment planning, training/education, etc.)

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Duration of time for 1 unit *(if applicable)*	Treatment Location	Attendance Type	Treatment Type
☐ 15 min	☐ Home	☐ Individual	☐ Assessment
☐ 30 min	☐ Clinic	☐ Family	☐ Therapy
☐ 45 min	☐ School	☐ Group	☐ Skills Training
☐ 60 min	☐ Other _____	☐ Other _____	☐ Other _____
☐ Other _____			

4. Requested CPT/HCPCS code _____ **Dates of service: From** _____ **to** _____

Number of units of this code billed within this time frame _____

A description of the physical service the member is receiving for this CPT/HCPCS code being billed
(i.e. counseling services, assessment, treatment planning, training/education, etc.)

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Duration of time for 1 unit *(if applicable)*	Treatment Location	Attendance Type	Treatment Type
☐ 15 min	☐ Home	☐ Individual	☐ Assessment
☐ 30 min	☐ Clinic	☐ Family	☐ Therapy
☐ 45 min	☐ School	☐ Group	☐ Skills Training
☐ 60 min	☐ Other _____	☐ Other _____	☐ Other _____
☐ Other _____			

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5. Requested CPT/HCPCS code _____ **Dates of service: From** _____ **to** _____

Number of units of this code billed within this time frame _____

A description of the physical service the member is receiving for this CPT/HCPCS code being billed
(i.e. counseling services, assessment, treatment planning, training/education, etc.)

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Duration of time for 1 unit *(if applicable)*	**Treatment Location**	**Attendance Type**	**Treatment Type**
☐ **15 min**	☐ **Home**	☐ **Individual**	☐ **Assessment**
☐ **30 min**	☐ **Clinic**	☐ **Family**	☐ **Therapy**
☐ **45 min**	☐ **School**	☐ **Group**	☐ **Skills Training**
☐ **60 min**	☐ **Other** _____	☐ **Other** _____	☐ **Other** _____
☐ **Other** _____			

6. Requested CPT/HCPCS code _____ **Dates of service: From** _____ **to** _____

Number of units of this code billed within this time frame _____

A description of the physical service the member is receiving for this CPT/HCPCS code being billed
(i.e. counseling services, assessment, treatment planning, training/education, etc.)

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Duration of time for 1 unit *(if applicable)*	**Treatment Location**	**Attendance Type**	**Treatment Type**
☐ **15 min**	☐ **Home**	☐ **Individual**	☐ **Assessment**
☐ **30 min**	☐ **Clinic**	☐ **Family**	☐ **Therapy**
☐ **45 min**	☐ **School**	☐ **Group**	☐ **Skills Training**
☐ **60 min**	☐ **Other** _____	☐ **Other** _____	☐ **Other** _____
☐ **Other** _____			

Other Comments

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My signature confirms that I am providing the requested services:

Signature _____ **Date** _____