



Therapeutic Behavioral On-Site Services Request

Provider must call BCBSIL 800-851-7498 to verify benefits. To expedite the processing of your request, please complete all sections of the form. Please fax to BCBSIL at 877-361-7656.

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, 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.)

Description of service text area

Table with 4 columns: Duration of time for 1 unit, Treatment Location, Attendance Type, Treatment Type. Includes checkboxes for 15 min, 30 min, 45 min, 60 min, Other, Home, Clinic, School, Other, Individual, Family, Group, Other, Assessment, Therapy, Skills Training, Other.



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.)

Duration of time for 1 unit <i>(if applicable)</i>	Treatment Location	Attendance Type	Treatment Type
<input type="checkbox"/> 15 min	<input type="checkbox"/> Home	<input type="checkbox"/> Individual	<input type="checkbox"/> Assessment
<input type="checkbox"/> 30 min	<input type="checkbox"/> Clinic	<input type="checkbox"/> Family	<input type="checkbox"/> Therapy
<input type="checkbox"/> 45 min	<input type="checkbox"/> School	<input type="checkbox"/> Group	<input type="checkbox"/> Skills Training
<input type="checkbox"/> 60 min	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> 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.)

Duration of time for 1 unit <i>(if applicable)</i>	Treatment Location	Attendance Type	Treatment Type
<input type="checkbox"/> 15 min	<input type="checkbox"/> Home	<input type="checkbox"/> Individual	<input type="checkbox"/> Assessment
<input type="checkbox"/> 30 min	<input type="checkbox"/> Clinic	<input type="checkbox"/> Family	<input type="checkbox"/> Therapy
<input type="checkbox"/> 45 min	<input type="checkbox"/> School	<input type="checkbox"/> Group	<input type="checkbox"/> Skills Training
<input type="checkbox"/> 60 min	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> 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.)

Duration of time for 1 unit <i>(if applicable)</i>	Treatment Location	Attendance Type	Treatment Type
<input type="checkbox"/> 15 min	<input type="checkbox"/> Home	<input type="checkbox"/> Individual	<input type="checkbox"/> Assessment
<input type="checkbox"/> 30 min	<input type="checkbox"/> Clinic	<input type="checkbox"/> Family	<input type="checkbox"/> Therapy
<input type="checkbox"/> 45 min	<input type="checkbox"/> School	<input type="checkbox"/> Group	<input type="checkbox"/> Skills Training
<input type="checkbox"/> 60 min	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____			



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.)

Duration of time for 1 unit <i>(if applicable)</i>	Treatment Location	Attendance Type	Treatment Type
<input type="checkbox"/> 15 min	<input type="checkbox"/> Home	<input type="checkbox"/> Individual	<input type="checkbox"/> Assessment
<input type="checkbox"/> 30 min	<input type="checkbox"/> Clinic	<input type="checkbox"/> Family	<input type="checkbox"/> Therapy
<input type="checkbox"/> 45 min	<input type="checkbox"/> School	<input type="checkbox"/> Group	<input type="checkbox"/> Skills Training
<input type="checkbox"/> 60 min	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> 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.)

Duration of time for 1 unit <i>(if applicable)</i>	Treatment Location	Attendance Type	Treatment Type
<input type="checkbox"/> 15 min	<input type="checkbox"/> Home	<input type="checkbox"/> Individual	<input type="checkbox"/> Assessment
<input type="checkbox"/> 30 min	<input type="checkbox"/> Clinic	<input type="checkbox"/> Family	<input type="checkbox"/> Therapy
<input type="checkbox"/> 45 min	<input type="checkbox"/> School	<input type="checkbox"/> Group	<input type="checkbox"/> Skills Training
<input type="checkbox"/> 60 min	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____			

Other Comments

My signature confirms that I am providing the requested services:

Signature _____ Date _____