BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

CERTIFICATE OF NEED (CON)

Fax Forms to 480-760-4732

Instructions: A CON must be completed Prior to admission or at time of admission, or For emergency admission, within 72 hours, or if an individual applies for Medicaid Assistance while in the hospital before Medicaid funding is authorized.

Date and Time of CON: ☐ AM ☐ PM

Type of Service Requested: ☐ Inpatient Psychiatric Hospital ☐ Subacute ☐ BHIF-RTC

Member name: Date of Birth:

Address: City/State: Zip Code:

AHCCCS ID: Auth Number:

Diagnosis (Must be numeric value per ICD 10 criteria):

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient. Explain: (MUST CHOOSE AT LEAST ONE)

   ☐ Imminent, recent, recurring or frequently intermittent episodes of risk of danger to self or other as a result of a treatable mental disorder or treatment;

   ☐ Disturbance of mood, thought or behavior which renders the patient incapable of developmentally appropriate self-care or self-regulation as a result of a treatable mental disorder;

   ☐ Requires multi-specialty services only available in an inpatient setting at this frequency or intensity;

   ☐ Outpatient services have failed to provide adequate treatment;

   ☐ Other:

2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. Explain (MUST CHOOSE AT LEAST ONE)

   ☐ Has known medical risk factors or side effects which complicate treatment;

   ☐ Needs physician or nursing observation and control of behavioral/functioning for diagnostic evaluation and treatment planning;

   ☐ Needs ongoing physical assessments, medication administration and/or laboratory monitoring which can not be reasonably provided at a lower level of care;

☐ Care is complicated and requires integration of multi-specialty services to form cohesive treatment;

☐ Other:

3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed. Explain (MUST CHOOSE AT LEAST ONE)

☐ Individual is suffering from an acute incident or exacerbation of a treatable mental disorder that can be expected to resolve with proper diagnosis and management.

☐ Other:

Level I Provider Name:

Requested Date of Admission:

Requested Service Dates - From: to Discharge:

☐ I am aware of the members' condition and have been provided with sufficient information to determine that this level of care is appropriate.

Physician's Signature: Date:

Print Name: