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

Recertification of Need (RON)

Fax Forms to 480-760-4732

Instructions: For persons 21 years of age or older a RON must be completed at least every 60 days. For persons under the age of 21 the treatment plan must be completed and reviewed every 30 days. The completion and review of the treatment plan meets the requirement for the re-certification of need.

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):

Date Due:

Date and Time RON completed: Admission Date:

Diagnosis (Must be numeric value per ICD 10 criteria:

Reason for Continued Stay: Check at least ONE from both A and B, or C and check ALL that apply from the Continued Stay Criteria below

A. Severity of Illness: (explain below)

☐ Persistence of disabling symptoms;

☐ Serious adverse reaction or non-response to medication, procedures, or therapy;

☐ Failure to attain treatment goals resulting in continuation of severe impairment of the client's physical, social, or behavioral functioning;

☐ Degree of illness precludes outpatient management; and

☐ Level I treatment course demonstrating lack of discharge readiness; e.g., Absent Without Leave (AWOL), suicide attempt, Dangerous To Others (DTO), Dangerous To Self (DTS)

B. Intensity of Service (explain below)

☐ Continues to need 24-hour/day close and continuous supervision of psychiatric condition;

☐ Significant impairment continues in familial, social, or academic environment;

☐ Pharmacotherapy with close observation and/or laboratory monitoring, and/or nursing supervision;

☐ Frequent redirection and/or observations which may include the use of time-outs, seclusion and restraint;

☐ The presence of a medical condition significantly hindering the treatment of the psychiatric condition.

C. Less restrictive resources available in the community still do not meet the treatment needs of the client. Please indicate why?

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

Physician's Signature: Date:

Print Name:

Level I Provider Name:

Requested Date of Admission:

Requested Service Dates - From: to Discharge: