BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

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FORM TO REQUEST DOCUMENTATION CONCERNING TREATMENT LIMITATIONS or MENTAL HEALTH PARITY INQUIRIES

Background: This is a tool to request information from Blue Cross® Blue Shield® of Arizona (BCBSAZ) about limitations that may affect your access to mental health or substance use disorder benefits. You can use this form to request general information about treatment limitations or specific information about limitations that may have resulted in denial of your benefits. An example of a request for general information might be a request for the plan's preauthorization policies for medical/surgical and mental health treatments. An example of a request for specific information related to a denial of benefits based on a failure to show medical necessity might be a request for the internal medical necessity guidelines used to deny your claim. BCBSAZ is required by law to provide you this information in certain instances.

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), many health plans and insurers must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that treatment limits applied to mental health and substance use disorder benefits must be at least as generous as the treatment limits applied to medical and surgical benefits. In other words, treatment limits cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements – such as deductibles, copayments, coinsurance, and out-of- pocket limits;
- Treatment limits – such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization to get treatment).

If you, a family member, or someone you are helping obtains health coverage through a private employer health plan, federal law requires the plan to provide certain plan documents about your benefits, including coverage limitations on your benefits, at your request. For example, you may want to obtain documentation as to why your health plan is requiring pre-authorization for visits to a therapist before it will cover the visits. Generally, BCBSAZ must provide the documents you request within thirty (30) calendar days of the plan's receipt of your request.

This form will help you request information from BCBSAZ about treatment limits on mental health and/or substance use disorder benefits. Many common types of treatment limits are listed on this form. If the type of treatment limit does not appear on the list, you may insert a description of the treatment limit you would like more information about under "Other."

Instructions: Complete the attached form to request general information from BCBSAZ about coverage limitations or specific information about why your mental health or substance use disorder benefits were denied. If you are helping someone with obtaining information about his/her health coverage, you are required to submit an authorization along with this form signed by the person you are helping.

Please send to:

BCBSAZ Mail Stop A114
PO Box 13466
Phoenix, AZ 85002-3466
OR Email: MHPinquiries@azblue.com

Date: _____/_____/_____

Mental Health and Substance Use Disorder Parity Disclosure Request

To: _____ [Insert name of the health plan or issuer]

(If you are a provider or another representative who is authorized to request information for the individual enrolled in the plan, complete this section.)

I am an authorized representative requesting information for the following individual enrolled in the plan:
Attached to this request is an authorization signed by the enrollee.

(Check the box to indicate whether your request is for general information or specific information related to your claim or denial for benefits.)

☐ **General Information Request**

I am requesting information concerning the plan's treatment limitations related to coverage for:

Mental health and substance use disorder benefits, generally. The following specific treatment for my condition or disorder:

_____

☐ **Claim/Denial Information Request**

I was notified on _____/_____/_____ [Insert date of denial] that a claim for coverage of treatment for_____ ____[Insert mental health condition or substance use disorder] was, or may be, denied or restricted for the following reason(s) shown immediately below:

(Based on your understanding of the denial of, limitation on, or reduction in coverage, check all that apply)

☐ I was advised that the treatment was not medically necessary.
☐ I was advised that the treatment was experimental or investigational;
☐ The plan requires authorization before it will cover the treatment;
☐ The plan requires ongoing authorizations before it will cover my continued treatment.
☐ The plan is requiring me to try a different treatment before authorizing the treatment that my doctor recommends.
☐ The plan will not authorize any more treatments based on the fact that I failed to complete a prior course of treatment.
☐ The plan's prescription drug formulary design will not cover the medication my doctor is prescribing.
☐ My plan covers my mental health or substance use disorder treatment, but does not have any reasonably accessible in-network providers for that treatment.
☐ I am not sure how my plan calculates payment for out-of-network services, such as its methods for determining usual, customary and reasonable charges, complies with parity protections.
☐ Other: *(Specify basis for denial of, limitation on, or reduction in coverage):*

_____
_____
_____

Because my health coverage is subject to the parity protections, treatment limits cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits. Therefore, for the limitations or terms of the benefit plan specified above, **within thirty (30) calendar days of the date appearing on this request,** I request that the plan:

1. Provide the specific plan language regarding the limitation and identify all of the medical/surgical and mental health and substance use disorder benefits to which it applies in the relevant benefit classification;
2. Identify the factors used in the development of the limitation (examples of factors include, but are not limited to, excessive utilization, recent medical cost escalation, high variability in cost for each episode of care, and safety and effectiveness of treatment);
3. Identify the evidentiary standards used to evaluate the factors. Examples include, but are not limited to, the following:

    - Excessive utilization as defined by two standard deviations above average utilization per episode of care;
    - Recent medical cost escalation as defined by medical costs for certain services increasing 10% or more per year for 2 years;
    - High variability in cost per episode of care as defined by episodes of outpatient care being 2 standard deviations higher in total costs than the average cost per episode 20% or more of the time in a 12-month period; and
    - Safety and efficacy of treatment modality as defined by 2 random clinical trials required to establish a treatment is not experimental or investigational;
4. Identify the methods and analysis used in the development of the limitation; and
5. Provide any evidence and documentation to establish that the limitation is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

(Complete this section for all requests)

_____

Printed Name of Individual Enrolled in the Plan or his or her Authorized Representative

I am an authorized representative requesting information for the following individual enrolled in the plan:

_____

Attached to this request is an authorization signed by the enrollee.

_____

Signature of Individual Enrolled in the Plan or his or her Authorized Representative

Member Number (number assigned to the enrolled individual by the Plan): _____

Address: _____

Date: _____/_____/_____

E-mail address (if email is a preferred method of contact): _____

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