

Fax this form with all applicable information documented to: **1-833-719-1607**.
A review can **NOT** be completed without the necessary information. *Print legibly.*

Instructions on next page.

Contract Number (include prefix)		Group Number	Subscriber Name (last, first, middle initial)	
Patient Name (last, first, middle initial)		Date of Birth	Ordering Provider's Name (first and last)	
Ordering Provider NPI	Ordering Provider's Phone	Address of Ordering Provider		
Therapist Name		Therapist NPI	Therapist Office Phone Number	Therapist Office Fax Number
Therapist Facility Name		Therapist Facility Address		
Primary Diagnosis Code		Onset Date	Secondary Diagnosis Code (optional)	Onset Date
Check All that Apply:				
Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Surgery: _____	Type of Surgery: _____
Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Injury: _____	Type of Injury: _____
Has patient had previous therapy for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Date: _____				
List medical or surgical complications and date related to current treatment: _____				

LIST ALL DATES OF SERVICE FOR THE CURRENT CALENDAR YEAR BEGINNING WITH JANUARY 1st:

1	2	3	4	5	6	7	8
9	10	11	12	13	14	15	

In order to review for medical necessity, please submit ALL of the following:

- _____ Initial evaluation
- _____ Re-evaluation
- _____ Current MD Script with a medical diagnosis on the physician's letterhead/script
- _____ Last 5 treatment/daily notes WITH exercise flow sheets
- _____ Plan of Care/Progress Report (no older than 14 days) that includes updated objective measurements for long and short term goals, functional ADL skills, functional mobility, overall functional ability/skill, and new goals completed by OT/OTR.
- _____ Psychological evaluation in which testing for autism was completed.
- _____ Number of visits requested for this certification (frequency and duration) _____
- _____ Projected end date/discharge of therapy _____

Appeal

_____ Submit any additional documentation/information to support medical necessity of continuation of skilled therapy.

Instructions for completing the OCCUPATIONAL THERAPY PRECERTIFICATION REVIEW

Print legibly.

1. **Contract Number:** Enter Blue Cross contract number. **Prefix of contract number must be included.**
2. **Group Number:** Enter group number located on patient's Blue Cross identification card.
3. **Subscriber Name:** Enter name of contract holder from Blue Cross identification card. Enter last name, followed by first name and middle initial.
4. **Patient Name:** Enter patient's last name, followed by first name and middle initial.
5. **Date of Birth:** Enter patient's date of birth, include month, date and year.
6. **Ordering Provider's Name:** Enter first and last name of ordering provider.
7. **Ordering Provider NPI:** Enter the ordering provider's NPI.
8. **Ordering Provider's Phone Number:** Enter the telephone number, including area code of ordering provider.
9. **Address of Ordering Provider:** Enter street address of ordering provider, including city, state and zip code.
10. **Therapist Name:** Enter name of licensed physical therapist providing the care.
11. **Therapist NPI:** Enter the NPI of licensed therapist providing the care. If the therapist is hospital-based, enter the hospital's NPI.
12. **Therapist Office Phone Number:** Enter the telephone number, including area code, of therapist's office.
13. **Therapist Office Fax Number:** Enter fax number, including area code, of therapist's office.
14. **Therapist Facility Name:** Enter name of facility where therapy is to be performed.
15. **Therapist Facility Address:** Enter address of facility where therapy is to be performed, including city, state and zip code.
16. **Primary Diagnosis Code:** Enter diagnosis code of diagnosis for which patient is being treated and the onset date.
Do not use "V" codes. **All diagnoses should be specific to at least the 4th digit (i.e., 724.0).**
17. **Secondary Diagnosis Code:** Enter any other diagnosis codes that pertain to patient, **specific to at least the 4th digit (724.0) and the onset date.**
18. **Surgery:** Check Yes or No.
19. **Date of Surgery:** Enter the date surgery was performed.
20. **Type of Surgery:** Enter the type of surgery performed.
21. **Injury:** Check Yes if patient sustained an injury prior to or during therapy.
22. **Date of Injury:** Enter onset date of injury.
23. **Type of Injury:** Enter the type of injury sustained.
24. **Has patient had previous therapy for this condition?** Check Yes if patient has received prior therapy for same condition at your facility or another facility and enter dates of prior therapy.
25. **List medical or surgical complications and date related to current treatment:** Enter any complications the patient has sustained and the date the complication occurred.
26. **List all dates of service for the current calendar year:** Prior to each precertification/recertification, provider should verify contract benefits to determine number of visits required prior to certification requests.
In addition to this form, please fax medical records for the initial evaluation; the last five treatment notes and exercise flowsheets, therapy order, plans and goals; and current reassessment, if applicable.
27. **Appeal:** Check this box if you have received notification of non-certification of additional visits and are requesting an appeal.

To request an expedited appeal for this patient/member, submit any new/additional clinical indicators to support the medical necessity of continuation of skilled therapy. The appeal process will begin when all clinical information necessary to make a review determination is received. The entire medical record is not needed for the expedited appeal.

