BlueCross BlueShield Minnesota

SPEECH THERAPY PRECERTIFICATION REVIEW

Fax this form with all applicable information documented to: **1-833-731-1511**.
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 ☐ **Yes** ☐ **No** **Date of Surgery:** _____ **Type of Surgery:** _____

Injury ☐ **Yes** ☐ **No** **Date of Injury:** _____ **Type of Injury:** _____

Has patient had previous therapy for this condition? ☐ **Yes** ☐ **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 (baseline and current), functional communication skills, overall speech intelligibility, use of home program, and new goals completed by the CCC-SLP.

____ 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 SPEECH 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.

BlueCross BlueShield Minnesota