

THERAPY PRECERTIFICATION REVIEW

Please print legibly.

1. Contract Number: Enter Blue Advantage® contract number. **Prefix of contract number must be included.**
2. Group Number: Enter group number located on patient's Blue Advantage identification card.
3. Subscriber Name: Enter name of contract holder from Blue Advantage 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. Referring Physician's Name: Enter first and last name of referring M.D.
7. MD UPIN: Enter the referring physician's UPIN#, (available on the web at www.bcbsal.com).
8. Address of Referring M.D.: Enter street address of referring M.D., including city and state.
9. Therapist Name: Enter name of licensed physical therapist providing the care.
10. THERAPIST Provider Number: Enter 5-digit provider number of licensed physical therapist providing the care. If physical therapist is hospital based, enter the hospital provider number.
11. Therapist Office Fax Number: Enter fax number, including area code, of physical therapist's office.
12. Therapist Facility Name: Enter name of facility where physical therapy is to be performed.
13. Therapist Address: Enter address of facility where physical therapy is to be performed, include city and state.
14. Therapist Telephone Number: Enter telephone number of facility, including area code.
15. Therapist E-mail address: Enter e-mail address of physical therapist at facility where physical therapy is to be performed.
16. Primary ICD 9 Code: Enter ICD 9 code of diagnosis for which patient is being treated and the onset date. Do not use V codes. **All Dx should be specific to at least the 4th digit (724.0).**
17. Secondary ICD 9 Code: Enter any other ICD 9 codes that pertain to patient, **specific to at least the 4th digit (724.0) and the onset date.**
18. Surgery: Check "Y" for yes or "N" for no.
19. Date of Surgery
20. Type of Surgery
21. Injury: Check "Y" for yes if patient sustained an injury prior to or during therapy.
22. Onset Date: 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 "Y" for yes, if patient has received prior therapy for same condition at your facility or another facility. If yes, enter dates of prior therapy.
25. Please list the dates of any injuries or complications that may impact treatment.
 - Initial Certification: Check this box if this is the first request for additional visits.
 - Additional Certification: Check this box if requesting additional visits after the initial request.
 - Appeal: Check this box if you have received notification of non-certification of additional visits and are requesting an appeal.
26. List Dates of Service for the current calendar year: these are actual treatments performed for the current year at this facility/tax ID number. Prior to each pre-certification/re-certification provider, should verify contract benefits to determine # of visits required prior to certification requests.

To request an expedited appeal for this patient/member please 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
of Alabama**

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