

OCCUPATIONAL THERAPY PRECERTIFICATION REVIEW

Please fax this form with all applicable information documented. If information required is not given, a precertification cannot be completed.



PLEASE RETURN THIS FORM TO:
BLUE CROSS BLUE SHIELD OF ALABAMA
 FAXPRESS: (205) 402-9369

Please print legibly (please note there are two pages of information)

Initial Certification Recertification Appeal

1) Patient Name (last, first, middle initial)		2) Date of Birth	3) Therapy Start Date
4) Contract Number (include prefix)	5) Group Number	6) Subscriber Name (last, first, middle initial)	
7) Referring Physician's Name (first and last)		8) MD Provider Number	9) Address of referring MD
10) O.T. Name	11) O.T. Provider #	12) O.T. Office Fax Number	13) O.T. Facility Name
14) O.T. Address		15) O.T. Telephone	16) O.T. Email Address
17) Primary ICD 9 Code (do not use V Code)		18) Secondary ICD 9 Code	19) # of visits requested for this precert
20) # of visits completed to date	21) Therapy begin date for this certification	22) Projected End Date of Therapy	

Check all that apply:

23) Surgery Y N Date: _____ Type Surgery: _____

24) Injury Y N 25) Onset Date: _____ 26) Type Injury: _____

27) Has patient had previous therapy for this condition? Y N – If Yes: Date: _____

28) Do you have a signed MD referral on file for this treatment? Y N If Yes: Date of referral: _____

29) Does referral give specific MD instructions, frequency, duration? Y N – If Yes: _____

30) LIST DATES OF SERVICE FOR LAST 15 TREATMENT DATES:

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

31) PAIN SCALE 1-10



0 **5** **10**
 NO PAIN MOD WORST PAIN
 (x – initial, 0 – current)

32) LOCATION: _____

33) ADL FUNCTIONAL STATUS:

Hygiene: _____
Feeding: _____
Toileting: _____
Dressing: _____
Bathing: _____

	Prior	Initial	Current
Independent	_____	_____	_____
Min Assist (25%)	_____	_____	_____
Mod Assist (50%)	_____	_____	_____
Max Assist (75%)	_____	_____	_____
Dependent	_____	_____	_____

34) Patient's current occupation: _____

What specific limitations does the patient have that impact job-related activities?: _____

Please outline treatment goals specific to these limitations: _____

35) Patient Name: _____ Patient Contract Number: _____ Pg. 2 OT Precert

36) WOUNDS / BURNS: SITE: _____ DESCRIPTION (drainage, color, odor): _____

37) WOUNDS / BURNS MEASUREMENTS:

INITIAL DATE: _____	REASSESSMENT DATE: _____	REASSESSMENT DATE: _____

38) JOINT ASSESSMENT: LOCATION, ROM, EDEMA, INFLAMMATION

INITIAL DATE: _____	REASSESSMENT DATE: _____	REASSESSMENT DATE: _____

39) MUSCLE PERFORMANCE / STRENGTH OF AFFECTED SITE:

INITIAL DATE: _____	REASSESSMENT DATE: _____	REASSESSMENT DATE: _____

40) SPECIFIC MEASURABLE GOALS (LONG TERM AND SHORT TERM):

INITIAL DATE: _____	REASSESSMENT DATE: _____	REASSESSMENT DATE: _____

41) TREATMENT PLAN (including frequency and duration) – Include complications / limitations that may affect progress:
