BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

OCCUPATIONAL THERAPY PRECERTIFICATION REVIEW

Fax this form with all applicable information documented to: **205-402-9369**.
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, 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.

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