BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

PHYSICAL THERAPY PRECERTIFICATION REVIEW

Fax this form with all applicable information documented to: **205-220-0941**.
A review cannot be completed without the necessary information.

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 National Provider Identifier (NPI)	**Address of Ordering Provider**		
Therapist Name	**Therapist NPI**	**Therapist Office Phone Number**	**Therapist Office Fax Number**
Therapist Facility Name	**Therapist Facility Address**	**Therapist Email Address**	
Primary Diagnosis Code (do not use "V" codes) **Onset Date**	**Secondary Diagnosis Code*** (do not use "V" codes) **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	

☐ **Initial Certification**

____ Copy of initial evaluation ____ Current MD Order ____ Last 5 treatment notes/exercise flow sheets

____ Current reassessment with objective findings, updated goals, progress toward goals, current treatment plan, including frequency/duration – **performed at 15th visit**

Number of visits requested for this certification _____

Projected end date of therapy _____

____ **Justify the need for continuation of therapy**.

☐ **Additional Certification**

____ Current ordering provider

____ Treatment notes from previously certified visits, exercise flow sheets. Documentation should include objective findings/functional limitations and any additional information from last certified visit to support medical necessity for additional visit.

Number of visits requested for this certification _____

Projected end date of therapy _____

____ **Document changes in treatment plan and/or the patient's condition to warrant the course of treatment**.

☐ **Appeal**

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

* Optional

Instructions for completing the PHYSICAL 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. **Address of Ordering Provider:** Enter street address of ordering provider, including city, state and zip code.
9. **Therapist Name:** Enter name of licensed physical therapist providing the care.
10. **Therapist NPI:** Enter the NPI of licensed physical therapist providing the care. If the physical therapist is hospital-based, enter the hospital's NPI.
11. **Therapist Office Phone Number:** Enter the telephone number, including area code, of physical therapist's office.
12. **Therapist Office Fax Number:** Enter fax number, including area code, of physical therapist's office.
13. **Therapist Facility Name:** Enter name of facility where physical therapy is to be performed.
14. **Therapist Facility Address:** Enter address of facility where physical therapy is to be performed, including city, state and zip code. .
15. **Therapist Email Address:** Enter email address of physical therapist at facility where physical therapy is to be performed.
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. **Initial Certification:** Check this box if this is the first request for additional visits.
28. **Additional Certification:** Check this box if requesting additional visits after the initial request.
29. **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.