Capital BLUE

Physical/Occupational Therapy Treatment Plan

Fax completed form to: 717.540.2440

To ensure accurate and timely processing of your request, please complete all fields on the form.

SECTION I—Member Information

Member Name:		Member ID:		Date of Birth:
Plan Type:	☐ Traditional	☐ BlueJourney PPO	☐ PPO	☐ Comprehensive
	☐ BlueJourney HMO	☐ POS	☐ HMO	
Does member have other primary insurance?	☐ N/A	☐ Workers' Comp	☐ Auto	☐ Other:
Have member's benefits been verified?	☐ Yes	☐ No		

SECTION II—Level of Urgency

Authorization Type: ☐ Initial ☐ Reauthorization (Subsequent)

Level of Urgency:

☐ **Standard** Request (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature.

☐ **Expedited** Request—Care/treatment that is emergent or the application of the timeframe for making Standard/Routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For Expedited Request, Please Explain:

SECTION III—Authorization

Start Date:	End Date:	Number of visits requested for 60 days:
Primary Diagnosis:	Additional Diagnosis:	
Service Type: ☐ PT ☐ OT	Primary Procedure Code(s):	
Place of Service: ☐ Inpatient ☐ Outpatient ☐ Home ☐ Other:		

SECTION IV—Servicing/Performing Provider Information

Name:	NPI:
If Service/Procedure is being done in a Facility, name of Facility:	Facility NPI (if known):

☐ Local Blue Plan (if yes, please provide Local Blue Plan identification)

Address:		
City:	State:	ZIP Code:
Contact Name:	Contact Phone:	Fax:

SECTION V—Referring Provider Information (if different than above)

Name:	Requesting Provider NPI:	
Address:		
City:	State:	ZIP Code:
Contact Name:	Contact Phone:	Fax:

SECTION VI—Additional Information Required

☐ Fax along with this cover sheet the initial evaluation or progress notes, and any additional clinical documentation related to this request.

Any questions, contact Capital BlueCross Preauthorization department at 800.471.2242

Please Sign:	Date:

(Preauthorization is not a guarantee of payment.)