

Outpatient Pre-Treatment Authorization Program (OPAP) Request

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| INSTRUCTIONS | | | |
| Participating Providers: to initiate a request and to check the status of your request, visit CareFirst Direct at carefirst.com . Please print and complete entire form. Fax form to 410-505-6404 . | | | |
| Check all that apply: <input type="checkbox"/> Physical Therapy (PT) <input type="checkbox"/> Occupational Therapy (OT) <input type="checkbox"/> Acupuncture <input type="checkbox"/> Speech Therapy (ST) <input type="checkbox"/> Spinal Manipulation/Chiropractic Habilitative <input type="checkbox"/> Yes <input type="checkbox"/> No When submitting claims for Habilitative Services, the modifier 96 must be included. When submitting claims for Rehabilitative Services, the modifier 97 must be included. | | | |
| CASE INFORMATION | | | |
| Patient Name (Last, First) | | Subscriber Member ID# | |
| Date of Birth (mm/dd/yyyy) / / | Gender <input type="radio"/> Male <input type="radio"/> Female | Number of Visits | Date of Service (mm/dd/yyyy) From / / to / / |
| Diagnosis Code(s) (ICD-10) Primary | | Secondary | |
| Servicing Practitioner | | BlueChoice Regional Provider ID # (Tax ID # if non-participating) | |
| Office/Facility Name | | Practitioners Address | |
| City | State | Zip Code | Treatment Setting <input type="radio"/> Office <input type="radio"/> Outpatient Facility |
| CONTACT INFORMATION | | | |
| Office Name | | Office Telephone # & Extension (including area code) | |
| Email Address | | Tax ID # | |
| Office Fax # | | | |
| AUTHORIZATION EXTENSION (IF APPLICABLE) | | | |
| Previous Authorization # | | Action Requested <input type="radio"/> Extend End Date <input type="radio"/> Add Visits | |
| Additional Comments | | | |
| DISCLAIMER | | | |
| The above approval is based on the number of visits recommended for the diagnosis indicated. If additional visits are required, please complete and submit a separate authorization form indicating measurable short-term and long-term goals for the member. Prior to rendering the authorized service, the health care practitioner must verify the member's eligibility and benefits with CareFirst (see page 2 for instructions). If the patient's benefits are not covered on the date the authorized service is delivered, reimbursement will not be provided. | | | |

FOR CAREFIRST USE ONLY

Visit(s) Authorized _____

- ☐ Physical Therapy (PT) ☐ Speech Therapy (ST) ☐ Acupuncture ☐ Spinal Manipulation / Chiropractic
☐ Occupational Therapy (OT) ☐ Rehabilitative ☐ Habilitative

OPAP Authorization # _____ ☐ No Preauthorization Required

OPAP Comments

IMPORTANT INFORMATION FOR COMPLETING REQUEST FORMS**1. Verify eligibility and benefits through the following**

- Online at carefirst.com/carefirstdirect.
- Maryland-based products (Maryland Point of Service, Preferred Provider Organization, Preferred Provider Network and Maryland Indemnity products) call BlueLine at 410-581-3535 or 800-248-8410.
- National Capital Area (NCA)/Regional-based products (CareFirst BlueChoice, CareFirst BlueChoice Opt-Out, CareFirst BlueChoice Opt-Out Plus, BluePreferred and NCA Indemnity) call FirstLine at 202-479-6560 or 800-842-5975.

2. General Instructions

- Type or print legibly and complete the form in its entirety. Note N/A in blocks that are not applicable.
- The number of visits and the range for dates of service must agree with those indicated on the claim form. (For example the number of visits cannot be overstated. A visit must not occur outside the approved range for dates of service.) If the claim does not agree with the authorization, claims processing may be delayed and/or the claim may be denied.
- To order additional forms, please call 410-998-4667. Use your Provider ID number to request the form number noted at the bottom of the first page.

3. Fax completed forms to 410-505-6404 within five days from initial evaluation. Delays may cause a denial or reduction in claims payment. Please do not send additional pages unless requested (see additional instructions for HMO). Once processed, your OPAP authorization will be faxed back to you.**Additional HMO Specific Requirements**

- For CareFirst BlueChoice, Inc. products (including BlueChoice HMO, Opt-Out, and Opt-Out Plus), a PCP may also be required to submit a written referral to a therapist for the first three visits (to include one evaluation and two treatments).
- Prior to rendering continued services beyond the initial three visits, the therapist must obtain OPAP authorization. Submit a copy of the written referral along with the OPAP Authorization Form (see General Instructions above).
- CareFirst BlueChoice Opt-Out with the Open Access feature (see patient's ID card) does not require written referrals for the first three visits. Chiropractic (spinal manipulation) services require authorization starting with the first visit.

Authorization requirements for health care services vary by employer. Be sure to check the patient's eligibility and benefits. Note Authorization is subject to medical necessity. Providers should be familiar with our medical policies as they pertain to Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) and spinal manipulation services. Medical policies are available on the "Providers & Physicians" section of our web site, carefirst.com. Please see Section 08, Rehabilitation Therapy, for details. This form is used to request continued services after the initial three referral visits have been completed.