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Anthem BlueCross BlueShield

OHIO COMMERCIAL THERAPY REQUEST FORM

Please fax to OrthoNet at: 1-844-216-1599

Fax Date: _____ # of Pages Faxed: _____

THERAPY PROVIDER INFORMATION

Facility or Provider Name

Street Address

City **State** **ZIP**

Telephone Number ( ) - **Fax Number*** ( ) -

** The above fax number will be used to confirm your address/location if we are unable to contact you using the fax number on file with Anthem.*

Billing National Provider Identifier (NPI)

Provider Tax ID Number

O Individual NPI Number O Group or Facility NPI Number O Individual Tax ID Number O Group or Facility Tax ID Number

PATIENT INFORMATION:

First Name **Last Name** **Date of Birth** Month / Day / Year

Alpha Prefix **Anthem Member ID Number**

REQUEST INFORMATION:

Request for:

O Onset (Commencement) of Therapy Services
O Extension of Therapy Services
O Existing case, new injury or condition
O Existing case, new episode or recurrence

Therapy Visits to Date for this condition:

Effective Date for this Request Month / Day / Year

Initial Evaluation Date Month / Day / Year

Date of Last Therapy Visit Month / Day / Year

Service Type:

O Physical Therapy
O Occupational Therapy

Setting:

O Office O SNF
O Outpatient Hospital O Home

Instructions:

1. Use this form when requesting prior authorization of therapy services for ANTHEM members.
2. **Please complete and Fax this request form along with all supporting clinical documentation to OrthoNet at 1-844-216-1599.** (Use this completed form with a HIPAA compliant cover sheet and include it before the supporting clinical documentation.)
3. Please ensure that this form is a DIRECT COPY from the MASTER.
4. Please PRINT, in black ink, one character per box for ALL requested information and completely fill in each circle for selection where applicable.
5. For assistance in completing this form, please call OrthoNet provider services toll free at 1-844-282-6994.

NOTE: The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material/information in error, please contact the sender and delete or destroy the material/information.

PF-AWI-0008-15

OrthoNet

Rev. 4/30/2018

For Internal Office Use Only
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Alpha Prefix **Anthem Member ID Number**

* ***Note:*** ***The above Member ID number MUST be Identical to the Member ID number provided on Page 1 of this form.)***

REQUEST INFORMATION

Condition Type: O Acute (less than 2 months) O Sub-acute (2-3 months) O Chronic (more than 3 months)

Primary Diagnosis Code ___.___ (ICD-10 Format)

Affected Region: O Right O Left O Bilateral O Not Applicable

Onset: O Insidious/No Trauma O Traumatic Injury O Repetitive Stress O Post-Operative
O Work-related O Motor Vehicle

For Post-Operative Cases Only:

Type of Surgery: O Joint Replacement O ACL Reconstruction O Rotator Cuff/Labral Repair O Spinal Fusion
O Arthroscopy O Tendon Repair O Other: _____

Date of Surgery
__ / __ / ____
Month Day Year

Chief Complaint(s):
O Pain O Stiffness O Weakness
O Loss of Balance O Decreased/Loss of Function
O Other: _____

Frequency of Symptoms:
O Constant O Frequent O Occasional O Intermittent

Impact of Symptoms on ADL:
O None O Minimal O Moderate O Significant

Pain Intensity (0-10): __ (Last 24 hours) __ (Past Week)

Muscle Strength (MMT): O 5/5 O 4/5 O 4-/5 O 3+/5 O 3/5 O 3-/5 O 2+/5 O 2/5 O 1/5 O 0/5

Active Range of Motion Limitations: O None O Minimal O Moderate O Significant

Functional Limitations: O None O Minimal O Moderate O Significant

Functional Measure Score (For Chief Complaint): ___ Most Recent Score

Form Type: O Neck O Back O SF 12/36
O LEFS O DASH O KSS
O Other: _____

Progress since first visit: O None, first visit O No Progress Yet O Some Progress O Significant Progress
O Significantly Worse

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PT/OT INITIAL EVALUATION REPORT

Today's Date: _____ Insurance Company: _____

Patient Name: _____ Patient ID #: _____

Date of Birth / Age: _____ Date Of Injury: _____ / _____ / _____ Date Of Surgery: _____ / _____ / _____

ICD-10 Code(s): _____ Diagnosis: _____

Referring Physician: _____ Referring Physician ID #: _____

Therapy Office: _____ Discipline: PT / OT

OBJECTIVE FINDINGS

Involved Region: Left / Right / N/A

Strength (0-5)		**Range of Motion**		
Motion	Grade	Motion	PROM	AROM

How / Where Injury Occurred: **Work Related?** Yes No

Pertinent History:

Pain: Pain Scale: /10 Nature: constant / intermittent / localized / radiating

Functional Deficits / Additional Information:

Specific Treatment Plan:

Treatment Goals:

Projected Frequency / Duration of Treatment

Therapist Signature: **Printed Therapist Name and License #:**

Created: 9/99 / Revised: 1/12, 10/15