BlueCare Tennessee
1 Cameron Hill Circle
Chattanooga, TN 373402
bluecare.bcbst.com

BlueCare℠
TennCare*Select*

Outpatient Therapy Request Form

BlueCare/TennCare*Select*
Fax Number: 1-800-292-5311

☐ **BlueCare**	☐ **TennCare*Select***

**Prior Authorization is not required for children under the age of 21
**Prior Authorization is not required for the initial visit for evaluation of member's outpatient therapy needs

Member Information

Member Name:

Member ID Number:

Date of Birth:

Diagnosis: *(List all)*

Therapy Provider Information

Ordering Physician:

Provider Number:

National Provider Identifier:

Tennessee Medicaid Number:

Phone Number:

Fax Number:

Contact:

Servicing Provider:

Provider Number:

National Provider Identifier:

Tennessee Medicaid Number:

Phone Number:

Fax Number:

Contact:

*A copy of the MD's written order (or details of the verbal order) must be submitted with this fax request.

Date of Evaluation:

Therapy Being Requested:

Number of treatments:

Frequency of treatments:

Pain Rating:

Date of Pain Rating:

Pain Location:

Conservative TX used and/or failed:

Date of previous treatment:

Date of last actual MD assessment/followup:

If this is post-operative therapy, what procedure:

Date of procedure:

If prior therapy, is there an HEP currently in place:

Is the patient compliant with HEP:

Problems:

1.

2.

3.

4.

Assistive Devices:

Rehab Potential:

Short Term Goals: (initial requests)

1.

2.

3.

4.

Target completion date

Long Term Goals: (initial requests)

1.

2.

3.

4.

Target completion date:

If therapy continuation, document the following: goals, progressing or not progressing, met: ROM/strength/functional limitations:

Date of the assessment:

Notification is not a confirmation of coverage or benefits.Benefits remain subject to all contract terms, benefit limitations, conditions, exclusions, and the patient's eligibility at the time services are rendered. This request may be subject to retrospective review based on Medical Policy.