Capital BLUE

Physical/Occupational Therapy Treatment Plan

(Preauthorization is not a guarantee of payment.)

Fax completed form to: **717.540.2440**

SECTION I—Member Information		
Member Name:	Member ID:	Member Date of Birth:
Plan Type: ☐ Traditional ☐ BlueJourney PPO ☐ PPO ☐ Special Care℠ ☐ Comprehensive ☐ BlueJourney HMO ☐ POS ☐ Keystone Health Plan® Central, Inc.		
Does member have other primary ☐ Workers' Comp ☐ Auto ☐ Other:		
Service for: ☐ PT ☐ OT ☐ ST		

SECTION II—Provider Information		
Referring Provider Name:		
Address:		
Telephone Number:	Fax Number:	
Name of Servicing Provider/Facility:	Facility/Servicing Provider ID Number (if known):	
Contact Name:	Contact Telephone Number:	
Address: City: State: ZIP:		

SECTION III—Preauthorization Requirements and Clinical Criteria	
☐ Initial Authorization (**Please include initial evaluation.**)	
☐ Reauthorization (**Please include current progress note.**)	
Number of Visits Requested for One Month:	Start Date for this Authorization:
Diagnosis Code:	Diagnosis Description:
Comments:	

Any questions, contact Capital BlueCross Preauthorization Department at 800.471.2242.

SECTION IV—Signature	
Please sign:	Date: / /