Capital **BLUC**

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: Me	ember ID:	Member Date of Birth:
Plan Type: Traditional BlueJourney PPO PPO Special Care SM Comprehensive BlueJourney HMO POS Keystone Health Plan [®] Central, Inc.		
Does member have other primary		
Service for: PT OT ST		
SECTION II—Provider Information		
Referring Provider Name:		
Address:		
Telephone Number:	Fax Number:	
Name of Servicing Provider/Facility:	Facilit know	y/Servicing Provider ID Number (if n):
Contact Name:	Contact Telephone I	Number:
Address:	City:	State: ZIP:
SECTION III—Preauthorization Requirements and Clinical Criteria		
☐ Initial Authorization (Please include initial evaluation.)		
Initial Authorization (Please include initial evalua	ition.)	
☐ Initial Authorization (Please include initial evaluation (Please include current progres		
		uthorization:
Reauthorization (Please include current progres Number of Visits Requested for One Month: Diagnosis Code:	ss note.)	
Reauthorization (Please include current progress Number of Visits Requested for One Month:	Start Date for this A	
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Reauthorization (Please include current progress Number of Visits Requested for One Month: Diagnosis Code: Comments:	Start Date for this Ai Diagnosis Description	n:

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.