OUTPATIENT PRE-TREATMENT AUTHORIZATION PROGRAM (O.P.A.P.)

CareFirst BlueCross BlueShield

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech/Language Pathology
- ☐ Spinal manipulation
- ☐ Rehabilitation
- ☐ Habilitation (0-19 years)

PART I:

1. PATIENT'S NAME (Last, First, Initial)

2. PATIENT'S DATE OF BIRTH
___ ___ / ___ ___ / ___ ___
Month Date Year

3. PATIENT'S SEX
☐ Male ☐ Female

4. RELATIONSHIP TO SUBSCRIBER
☐ Self ☐ Spouse ☐ Son ☐ Daughter

RETURN TO:
CAREFIRST BLUE CROSS BLUESHIELD
100 S. CHARLES STREET
BALTIMORE MD 21201

CERTIFICATE HOLDER INFORMATION

5. BLUE CROSS BLUE SHIELD MEMBERSHIP NUMBER
___ ___ ___ / ___ ___ / ___ ___ ___ ___

6. CERTIFICATE HOLDER'S NAME (Last, First, Initial)

7. CERTIFICATE HOLDER'S ADDRESS (Street, City, State, Zip)

8. CERTIFICATE HOLDER'S PLACE OF EMPLOYMENT

GROUP NUMBER

PART II: REQUEST FOR AUTHORIZATION

9. MEDICAL DIAGNOSIS (use ICD-9-CM codes)
☐ Primary
☐ Secondary

10. TREATMENT/PATIENT DIAGNOSIS
☐ Primary
☐ Secondary

11. CERTIFICATION
☐ Initial Certification
☐ Re-Certification

12. DATE TREATMENT BEGAN
___ ___ / ___ ___ / ___ ___
Month Date Year

13. PREFERRED PROVIDER?
☐ Yes ☐ No

14. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT ☐ Yes ☐ No
B. MOTOR VEHICLE ACCIDENT ☐ Yes ☐ No

15. AUTHORIZED SERVICES WILL BE PROVIDED BY:
AGENCY/PROVIDER LIC #
ADDRESS
CITY, STATE, ZIP
(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
PHONE NUMBER
(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
FAX NUMBER

16. BLUE SHIELD PROVIDER NO.

17. NAME OF REFERRING PHYSICIAN OR AGENCY

☐ Self-referred

18. IS PATIENT RECEIVING RELATED THERAPY SERVICES FROM ANOTHER PROVIDER?
☐ No ☐ ? ☐ Yes
Specify Provider:

19. BRIEFLY SUMMARIZE THE PROBLEM WHICH NECESSITATES THE NEED FOR THERAPY OR ATTACH DOCUMENTATION
Chief Complaint
History/Objective Findings

20. DESCRIBE YOUR ASSESSMENT OF THIS PATIENT'S POTENTIAL OR ATTACH DOCUMENTATION
(Including long and short term goals) ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ See attached documentation
SHORT TERM: 1.
2.
3.
LONG TERM: 1.
2.
3.

21. EVALUATION PREVIOUS PRESENT

Pain (1-10) _____

ROM (in degrees) _____

Strength 1-5 _____

ADL Level Independent _____

Min. Assist _____

Mod. Assist _____

Max. Assist _____

Therapeutic Procedures:

- ☐ Evaluation
- ☐ Periodic Consultation
- ☐ Develop/Upgrade Home Program
- ☐ Joint Mobilization
- ☐ Wheelchair Mobility
- ☐ Physical Performance Testing
- ☐ Self Care Mgmt/ADLs
- ☐ Cognitive Skills Development
- ☐ Therapeutic Activities/Functional Training
- ☐ Therapeutic Exercise
- ☐ Massage
- ☐ Cognitive Re-Training
- ☐ Sensory Perception Training
- ☐ Fabricate/Procure Adaptive Equipment
- ☐ Gross Motor Development
- ☐ Environment Assessment
- ☐ Community/Work Reintegration
- ☐ Other _____
- ☐ Neuromuscular Re-education
- ☐ Oral Motor Training
- ☐ Hand Dexterity
- ☐ Fabricate or Procure Splint/Orthotics
- ☐ Gait Training
- ☐ Myofascial Release/Stimulation
- ☐ Traction (manual)
- ☐ Orthotic/Prosthetic Training
- ☐ Home Program

Modalities:

(Supervised)

- ☐ Superficial Heat (specify _____)
- ☐ Traction (mechanical)
- ☐ Electrical Stimulation
- ☐ Whirlpool
- ☐ Vasopneumatic Device
- ☐ Other _____

(Direct Contact)

- ☐ Ultrasound
- ☐ Iontopharesis
- ☐ Electrical Stimulation
- ☐ Other _____

- ☐ Wound Management

Appearance of wound (size)

Previous: _____

Present: _____

Services	Frequency	Expected Duration	Short Term Treatment Goal
☐ Speech Therapy			
☐ Language Therapy			
☐ Fluency Training			
☐ Aural Rehabilitation			
☐ Swallowing Rehabilitation			
☐ Other (specify)			

PART III: FOR RECERTIFICATION ONLY

22A. BRIEFLY SUMMARIZE THIS PATIENT'S PROGRESS AND ANY OBJECTIVE/FUNCTIONAL CHANGES SINCE THE LAST TREATMENT PLAN WAS SUBMITTED AND RELATE THEM TO TREATMENT GOALS STATED IN QUESTION 20 ☐ See attached documentation

_____

_____

22B. COMPLICATIONS OR FACTORS LIMITING PROGRESS _____

_____

22C. REVISED FUNCTIONAL GOALS

SHORT TERM: 1. _____

2. _____

3. _____

LONG TERM: 1. _____

2. _____

3. _____

THERAPIST SIGNATURE: _____ LICENSE NUMBER: _____

THERAPIST'S NAME (PRINT): _____ STATE IN WHICH LICENSED: _____

REQUESTED NUMBER OF VISITS: _____ EXPIRATION DATE: ___ / ___ / __

FREQUENCY/DURATION: _____ DATE FORM COMPLETED: _____