62266

Fax Request Form

To: **OrthoNet** Fax #: **(866) 800-7485**

OrthoNet

Fax Date: _____ # of Pages Faxed:_____

Empire BLUECROSS BLUESHIELD

Instructions:

1. Use this form as a Fax Cover Sheet and send all supporting clinical data with this request
2. Please ensure that this form is a DIRECT COPY from the MASTER
3. Please PRINT, in black ink, one character per box for ALL requested information
4. Please completely fill in each circle that represents the corresponding NUMBER entry
5. For assistance in completing this form, please call OrthoNet Provider Services at (800) 448-6152

For Internal Office Use Only
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THERAPY PROVIDER INFORMATION

Facility Name

Or **Provider First Name** **Provider Last Name**

Street Address

City **State** **Zip**

Telephone Number **Return Fax Number**

( ) - ( ) -

Facility/ Provider ID Number **Provider Tax ID Number** **National Provider Identifier (NPI)**

○ **Facility Tax ID Number**
○ **Individual Tax ID Number**

○ **Facility NPI Number**
○ **Individual NPI Number**

PATIENT INFORMATION:

First Name **Last Name** **Date of Birth**

Month / Day / Year

Alpha Prefix **Member ID Number** **Diagnosis Code** (ICD-9 or ICD-10 Format)

REQUEST INFORMATION:

Request for:
○ Therapy Visits Precertification
○ Other Procedure: _____

Service Type:
○ Physical Therapy
○ Occupational Therapy

Is this request for post-operative therapy visits?
○ Yes ○ No

Initial Evaluation Date
Month / Day / Year

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Shade Circles Like This -----> ● Not Like This -----> ⊗ ∅