BlueCross BlueShield of Tennessee

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BlueAdvantage
Outpatient Therapy Authorization Request Form
Fax: 1-800-255-0244

Physical Therapy ☐ **Speech Therapy** ☐ **Occupational Therapy** ☐

Member Information

Member Name: ______________________________ Date of Birth: ____________________

ID Number: ____

Facility Information

Facility Name: ______________________________ Contact Name: ____________________

Address: ____

Phone Number: ____________________________ Fax Number: _____________________

Provider Number: __________________________ Tax ID Number: __________________

Provider Information

Provider Name: ______________________________ Contact Name: ____________________

Address: ____

Phone Number: ____________________________ Fax Number: _____________________

Provider Number: __________________________ Tax ID Number: __________________

Clinical Information

Diagnosis: ____

Type of Surgery (if applicable): _________________ Date of Surgery: __________________

Comorbidities: ____

Date(s) of Service Requested: From: __________________ To: ______________________

Requested Frequency of Visits: ____________________ Duration: ______________________

Please attach available supporting clinical information including patient's limitations, current treatment plans, goals, etc. For extension requests, please include therapist's notes including progress toward goals.

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