Fax Request Form

8048

OrthoNet

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

Fax Date: _____ # of Pages Faxed: _____

Empire **BLUECROSS**

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
○ A   ○ S   ○ P

THERAPY PROVIDER INFORMATION

Facility Name

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

Street Address

City   **State** **Zip**

Telephone Number
(___) ___ – ____

Return Fax Number
(___) ___ – ____

PATIENT INFORMATION

First Name

Last Name

Date of Birth
__ / __ / ____
Month **Day** **Year**

Alpha Prefix

Member ID Number

Relationship Code

Facility or Provider ID Number

REQUEST INFORMATION

Request for:
○ Therapy Visits Pre-Certification
○ Clinical Update- No Additional Visits Requested

Diagnosis (ICD-9 Format)

Service Type
○ Physical Therapy
○ Occupational Therapy
○ Home Health Services

Initial Evaluation Date
__ / __ / ____
Month **Day** **Year**

Requested # of Visits

8048

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