



**BlueCross BlueShield
of Tennessee**

P.O. Box 180205
Chattanooga, TN 37402

www.bcbst.com

THIS INFORMATION IS CONFIDENTIAL

**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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