

# Continuous Passive Motion in the Home Setting Prior Review Fax Form

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

**Servicing Provider:** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_  
**HCPCS Code:** \_\_\_\_\_

**Please answer the following questions:**  
 Does the member have any of the following conditions.....Yes (select condition below) No

**Total knee arthroplasty or revision with:**  
 \_\_\_\_\_ low postoperative mobility following total knee arthroplasty or revision  
**Specify complications or co-morbidities resulting in low postoperative mobility (other than routine knee arthroplasty or revision care):** \_\_\_\_\_  
 \_\_\_\_\_ inability to comply with rehab exercises (indicate one of the following):  
     \_\_\_\_\_ complex regional pain syndrome/reflex sympathetic dystrophy  
     \_\_\_\_\_ extensive arthrofibrosis or extensive fibrosis  
     \_\_\_\_\_ inability to be an active participant in physical therapy due to physical, mental or behavioral issues  
     \_\_\_\_\_ other (specify): \_\_\_\_\_

**Non-weight bearing rehabilitation period following intra-articular cartilage repair procedure of the knee (indicate which procedure):**  
 \_\_\_\_\_ microfracture or osteochondral grafting  
 \_\_\_\_\_ autologous chondrocyte implantation  
 \_\_\_\_\_ treatment of osteochondritis dissecans  
 \_\_\_\_\_ repair of tibial plateau fractures  
 \_\_\_\_\_ other procedure (specify): \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_ Date of procedure: \_\_\_\_\_  
 Date of discharge from hospital: \_\_\_\_\_  
 Effective: 01/10/11

**PHYSICIAN ATTESTATION:** By signing below, I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

**Please certify the following by signing and dating below:**

\*Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (\*Original Physician signature required. Stamped signatures not acceptable)

**For BCBSNC members and NC State Health Plan members, fax form to 1-800-228-0838**

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