

**BlueChoice HealthPlan Request for Extension of
Rehabilitation Services**



**Fax to Health Care Services
at (803) 714-6463 or 800-610-5685.**

Please allow 2 business days for return confirmation of certification.

P.O. Box 6170
Mail Code AX-325
Columbia, SC 29260-6170
803-786-8466

www.BlueChoiceSC.com

Date _____

Total # of Pages Included _____

Member Name _____

ID# _____ Date of Initial Eval _____

Diagnosis _____ Discipline PT OT ST

Total # Number of Visits Received _____ # Number of Visits Requested _____

Your Name _____ Your Phone # _____

Practice Name _____ Your Fax # _____

Please attach pertinent clinical documentation:

_____ Initial Evaluation

_____ Progress Notes, including summary progress, objective measurements and therapeutic exercise flow sheets since last request.

Comments: _____

For BlueChoice HealthPlan Use Only

Certification # _____ Total # of Visits Approved to Date _____

Expiration Date _____ Health Care Services Staff Initials _____

Additional Visits Approved _____

The attached information is confidential and is intended only for the use of the addressee identified above. If the reader of this message is not the intended recipient(s), be advised that any dissemination, distribution or copying of the communication is strictly prohibited. Anyone who receives this communication in error should notify us immediately by telephone (1-800-327-3183). The document can be faxed to us at (1-800-610-5685). After contacting us, the original document can be destroyed or returned to us via U.S. Mail by sending to the following address: BlueChoice HealthPlan, Mail Code AX-325, PO Box 6170, Columbia SC 29260-6170.