BlueCross BlueShield of North Carolina

In-Network Benefit Review Request

PRIOR REVIEW/CERTIFICATION

Request for Services Fax Form

Submission of this form is solely a notification for request for services and does not guarantee approval. All requests must be reviewed using authorization requirements by the prospective review area/department before authorization is granted. *Incomplete forms may delay processing. All NC Providers must provide their 5-digit BCBSNC provider ID# below.*

Patient Name	Blue Cross NC Member ID number	Patient D.O.B.
XXXXXXXXXXXX	XXXXXXXXX	XXXXXX
Patient Street Address XXXXXXX	City, State Raleigh, NC	Zip code XXXXX

Requesting Provider Information		**Servicing Provider** (if different from requesting provider) **Or Facility Location** (for services to be performed outside of the physician office)	
Provider Name and Specialty	Lutz, Alexander and Associates Nutrition Therapy	**Servicing Provider name and specialty (if different from ordering provider)**	Rachel Stratton
Provider # (or Tax ID or NPI # if No PPN)	NPI #1902457856	**Facility Name**	Lutz, Alexander and Associates Nutrition Therapy
Street, Bldg., Suite #	1042 Washington Street	**Servicing provider or Facility # (or Tax ID or NPI# if NO PPN)**	NPI #1538506423
City/State/Zip code	Raleigh, NC, 27605	**Street, Bldg., Suite # City/State/Zip code**	1042 Washington Street, Raleigh, NC, 27605
Phone #	919-781-4500	**Phone#**	919-781-4500
Fax #	919-781-4504	**Fax #**	919-781-4504
Contact person	Anna Lutz, MPH, RD, CEDRD-S		

ICD 10 Diagnosis Code(s):	271.3 Dietary Counseling and Surveillance	F50.01 Anorexia Nervosa, Restricting Type	
Other Diagnoses			
List all appropriate procedure codes (CPT, HCPCS)	97802-MNT	97803-MNT	

Please answer ALL questions
Fill in the appropriate response: Y= Yes ; N =No; NA = Not Applicable

If approval for In-network benefits is granted for a non-participating provider and/or facility, please note that all applicable service and procedure codes (even non-prior plan approval codes) and places of service must be requested and authorized in advance of services being performed. An approval, when granted, applies only to the provider who has been solely authorized.

In-Network Benefit Review Request
Prior Review Fax Form (page 2)

Patient Name	Blue Cross NC Member ID	Patient Date of Birth
XXXXX	XXXXX	XXXXXX

1. **As a Non-Participating Provider and/or Facility, please provide clinical details for making a request for authorization at the member's In-network benefit level** (you may include additional pages for supporting documentation):

See Attached

2. **If member is currently under your care, please provide date(s) of relevant member visit(s) within the last 12 months:**
4/6/20, 4/16/20, 4/27/20, 5/4/20, 5/11/20, 5/18/20, 6/1/20, 6/8/20, 6/28/20, 7/8/20, 7/16/20, 7/28/20, 8/10/20, 9/3/20, 9/7/20, 10/1/20, 10/6/20, 10/29/20, 11/13/20, 11/18/20, 12/4/20, 12/11/20, 12/21/20, 1/13/21, 1/19/21, 1/21/21, 1/28/21, 2/9/21, 2/25/21, 3/4/21, 3/11/21, 3/17/21, 3/23/21, 4/2/21, 4/5/21, 4/15/21, 4/30/21, 5/6/21, 5/10/21

3. ~~**For medical services that require prior authorization and certification to determine medical necessity for coverage:**~~
Do you have an existing certification or authorization for requested medical services? Y_____ N_X___*
If Yes:
a. Authorization/Reference Number: N/A
b. Date range of current authorization for services. From n/a to _____
c. Date of next scheduled appointment. n/a

***If NO**: A medical necessity coverage determination will be made at the same time as the decision for in-network benefits. Please note, decisions are distinct and may differ (i.e. prior authorization may be approved, but in-network benefits denied).

4. **For Maternity Related Requests:**
a. Estimated Delivery Date: n/a
b. Current patient trimester? 1st_____ 2nd_____ 3rd_____
c. Name of facility where delivery is planned? n/a

5. **Estimated date member would be able to transition to In-Network health care provider:** Sept 2021

(Please note this date is not guaranteed if your request is approved, but will be subject to a mutually agreed upon transition date with Blue Cross NC and the transitioning In-Network health care provider.)

****Please include clinical documentation and medical records to support request****

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 Blue Cross and Blue Shield of North Carolina (Blue Cross NC) may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.

Physician Signature:	[signature], RD, CEDRD	Date:	5/18/2021

Fax this form with required documentation to the appropriate fax number below:

Department	Fax Number	Department	Fax Number
Discharge Services	800.228.0838	Medical Drugs	800.795.9403
PPA/Case Mgmt/Acute Inpt	800.571.7942	SHP PPO PPA/UM	866.225.5258
		SHP PPO Transplant	919.765.1553

May 10, 2021

Patient Name: XXXXXX
DOB: XXXXXXX
Admission Date: April 6, 2020
Last attended session: January 28, 2021
ICD 10 Diagnosis: Z71.3 Dietary Counseling & Surveillance, F50.01 Anorexia Nervosa Restricting Type
Procedure Code (CPT): 97802 Medical Nutrition Therapy, 97803 Medical Nutrition Therapy

Clinical details for making request for authorization:
Patient is currently seeing a multidisciplinary treatment team for the treatment of an eating disorder in the outpatient setting. An essential component to patient's multidisciplinary treatment team is patient receiving **weekly medical nutrition therapy** from a Certified Eating Disorder Registered Dietitian, for patient to maintain her eating disorder recovery, prevent relapse, and most importantly prevent patient from admission to a Higher Level of Care.

I have been seeing this patient for medical nutrition therapy services over the past 13 months on a weekly basis. With ongoing medical nutrition therapy, patient has been able to achieve weight maintenance and adequate nourishment through the implementation of a structured meal plan prescribed by Registered Dietitian. Research shows that it is essential for patients in eating disorder recovery to receive ongoing outpatient treatment from a multidisciplinary treatment team, including nutrition services to prevent relapse. It is my clinical and professional recommendation to make this request for authorization as my patient is at **high risk for relapse** which would require admission to a higher level of care without outpatient treatment.

This patient was graciously authorized weekly (4.0 units per week) of medical nutrition therapy services between February 10-May 11, 2021, which has enabled this patient to maintain her eating disorder recovery and prevent admitting to a higher level of care for support. I am requesting a gap coverage, of weekly MNT appointments (4.0 units per week) so patient can continue to be successful in the outpatient setting. I am going on leave and this patient will be seeing Rachel Stratton (NPI: 1538506423) Thank you so much for your consideration for this authorization. Please do not hesitate to contact me or my supervisor directly at sara@lutzandalexander.com or anna@lutzandalexander.com for any follow up questions.

Sincerely,

Sara Gonet, MS, RD, LDN, CEDRD-S
Lutz, Alexander & Associates Nutrition Therapy
Raleigh, NC 27605

919-781-4500