



An Independent Licensee of the Blue Cross and Blue Shield Association

COGNITIVE REHABILITATION (97532*) TREATMENT PLAN

Use a Provider Service Inquiry form to request a review or denied claims.

Please print or type:

Patient Name: _____ ID#: _____

DOB: ____/____/____ Male Female Occupation: _____

Diagnosis: _____

Date of Injury/Condition: ____/____/____ Date First Seen for this Injury/Condition: ____/____/____ Days Lost from Work: _____

Cause of Injury: _____

Number of times the Patient has been treated for this condition, this calendar year: _____

Work Restrictions: _____

Effects on Activities of Daily Living: _____

Coordination of Care with Other Specialists: _____

Type of Care Given: _____

Current Examination & Diagnostic Findings, and Cognitive Deficits: _____

Treatment Goals with Expected Treatment Outcomes: _____

Describe Progress From Start of Care or Previous Review: _____

Requested Care



Provider Type: Psychologist D.O./M.D./P.A.

Procedures: _____

Anticipated Frequency & Duration: _____

Anticipated Date of Care: From ____/____/____ To ____/____/____

Provider Name: _____ Individual NPI (not group NPI): _____

Return Address: _____

Fax Number: _____ Phone Number: _____

Provider Signature: _____ Date: ____/____/____

Wellmark Use Only

Benefits Approved*: Beginning with Services On or After: _____

Number of Visits Approved: _____

Type: Psychologist D.O./M.D./P.A.

Frequency and Duration: _____

Benefits Denied: Not a benefit for this condition

Appears maintenance or supportive

Medical necessity not evident or treatment plan

_____/_____/_____
Date/Initials, Osteopathic/Medical Consultant

*Approvals are granted on the basis of the terms of this patient's contract benefits in effect on the date of the approval. If the patient's coverage changes before the service is provided, other limitations may apply; contact Wellmark for verification of membership.

In Iowa: fax to 515-376-9068 -or- mail to Treatment Authorization Sta 5C139 Wellmark Blue Cross and Blue Shield of Iowa, PO Box 9232, Des Moines, IA 50306-9232.
In South Dakota: fax to 877-505-3298 -or- mail to Treatment Authorization Sta 334, Wellmark Blue Cross and Blue Shield of South Dakota, 1601 W Madison Street, Sioux Falls, SD 57104.

Current Procedural Terminology (CPT) is copyright 2011 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT is a trademark of the American Medical Association.