BlueCross BlueShield of North Carolina

Nerve Fiber
Post Service - Information Request Form

Blue Cross NC will review associated claim(s) for services rendered on the patient listed below. In order to determine benefits are available for the reported condition, please answer the questions below. If you would prefer to send medical records, relating to the condition for the dates listed you may do so. In this case, all answers must be supported by documentation in the patient's medical record.

Please submit the completed form to Blue Cross NC per the Medical Record Submission instructions found on the bcbsnc.com provider site (https://www.bcbsnc.com/assets/providers/public/pdfs/submissions/how_to_submit_provider_initiated_medical_records.pdf) or if requested by Blue Cross NC via a bar-coded coversheet, please fax the form/medical records to the number noted on the bar-coded cover sheet within 7-10 days to facilitate the claim payment.

This form must be filled out by the patient's physician or their designee which may be any of the following: Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), or Licensed Practical Nurse (LPN).

Note: Credentials must be provided with signature or the form will be returned.

PROVIDER INFORMATION

Requesting Provider Information		**Place of Service**	
Provider Name		Facility Name	
Provider ID		Facility ID	

PATIENT INFORMATION

Patient Name:_____	Patient DOB :_____
Patient ID:_____	Patient Account Number_____

CLAIM INFORMATION

Date(s) of Service_____	**CPT_____**	**Diagnosis_____**

CLINICAL INFORMATION

1. Does the individual present with painful sensory neuropathy?

YES NO

2. Is there a history of a disorder known to predispose to painful neuropathy (e.g. diabetic neuropathy, toxic Neuropathy, HIV neuropathy, celiac neuropathy, inherited neuropathy)?

YES NO

3. Does physical examination shows no evidence of findings consistent with large-fiber neuropathy, such as reduced or absent muscle-stretch reflexes or reduced proprioception and vibration sensation.

YES NO

4. Are EMG and nerve-conduction studies normal and show no evidence of large-fiber neuropathy.

YES NO

5. List the date of the EMG and nerve conduction studies AND the type of study performed:

Date: _____

6. Is the nerve fiber density measurement being performed for monitoring disease progression?

YES NO

If yes, please indicate disease being monitored: _____

7. Is measurement of sweat gland nerve fiber density performed?

YES NO

If yes, please indicate date performed: _____

SIGNATURE

I certify that I have answered the questions above accurately and that my responses are supported by documentation in the patient's medical record. I understand that Blue Cross NC may at any time request medical records on this patient in order to validate my responses. If I am not the Patient's physician, I certify that I have explicit, delegated authority from the Patient's physician to provide these responses. I further understand that if I do not want to answer the questions provided, I may submit medical records for the above referenced patient relating to the service for the date listed above.

Signature: _____

Print Name: _____

Professional Degree: _____

Name of Patient's Physician (if signature above is not the patient's physician): _____

Date: _____