BlueCross BlueShield of North Carolina

Dermatology Patch Allergy Testing
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

Did the patient have direct skin testing (for immediate hypersensitivity) by:
Percutaneous or epicutaneous (scratch, prick, or puncture)? _____
Intradermal testing? _____

Inhalant allergy evaluation? _____

Did the patient have patch (application) testing (most commonly used: T.R.U.E. TEST by Allerderm):
Does the patient have persistent allergic contact dermatitis (ACD) after being previously evaluated and treated (including 6 weeks of avoidance of any allergens that were positive on initial patch testing, and use of topical steroid products if appropriate)? _____

OR
The patient has any of the following:
-At least 8 weeks of dermatitis without resolution with treatment

-Has a dermatitis that may be implanted device-related
-Is undergoing pre-testing for medical or dental device placement
-Requires extensive patch testing to determine if persistent dermatitis is allergic contact dermatitis
-Has seen at least one other physician who has requested specialty patch testing

AND
The dermatitis interferes with the patient's normal activities of daily living, such as occupational or work activities (use of hands), sleep patterns (due to itching), bathing or social interactions._____

If yes to both questions please note the number of patch tests:_____

Did the patient have a Photo-patch test? _____

If yes, was the results positive or negative? _____

Did the patient have one of the following IgE In Vitro Testing?
____Radioallergosorbent Test (RAST)
____Fluorescent Allergosorbent Test (FAST)
____Enzyme-linked Immunosorbent Assay (ELISA)
____Multiple Radioallergosorbent Tests (MAST)
____ImmunoCAP

Was the specific IgE in vitro tests for inhalant allergens (pollens, molds, dust, mites, animal dander) and foods or was the test for insect stings and other allergens (for example, drugs)? **Note: Circle whether test was for inhalant allergens/foods or insect stings/other allergens._____

If yes, was it due to one of the following reasons?
__Direct skin testing is impossible due to an extensive dermatitis or marked Dermagraphism.
__Direct skin testing is impossible such as in young children less than four years of age.
__Direct skin testing results are not consistent with a history of anaphylactic or other severe reaction to an allergen and further treatment decisions would be impacted by confirmation of sensitivity.
__Inability to discontinue medications (e.g. antihistamines) that impair skin test sensitivity.

If direct skin test, please note the number of tests:_____

<u>If none of the tests noted above, was the test one the following</u>:
__Total Serum IgE Concentration
__Double-blind Food Challenge Testing
__ALCAT
__Bronchial Challenge Testing
__Serial Dilution Endpoint Titration (SDET)
__MRT

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: _____