BlueCross BlueShield of North Carolina

Intraoperative Neurophysiologic Monitoring
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

Is the monitoring physician licensed in the state where the surgery was performed?
___YES ___NO

Is the monitoring physician privileged to interpret neurophysiologic testing in the hospital where the surgery was performed?
___YES ___NO

Does the monitoring physician have access to intraoperative neurophysiologic monitoring data in real-time from a remote location?
__YES ___NO

Indicate total number of cases monitored simultaneously during this time, including this case._____

Please attach the intraoperative neurophysiologic monitoring record indicating neurosurgical, orthopedic, or vascular procedure performed; methodology of monitoring; times of surgical events and procedures; and alerts issued to the surgeon or anesthesiologist.

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: _____