

**Review Request  
for Allergy Testing**

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 02/26/09	Policy Effective Date: 04/22/09	Provider Tool Effective Date: 08/31/09
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Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:

Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Facility Name:	Facility ID Number:
Facility Address:	

Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	

**Please check all that apply to the member:**

- Request is for allergy testing in a member with a history consistent with allergy disease (check all that apply):
- |   |   |
|---|---|
| <input type="checkbox"/> Bronchial challenge tests  | <input type="checkbox"/> Intracutaneous (intradermal) tests               |
| <input type="checkbox"/> Percutaneous (scratch, prick or puncture) tests  | <input type="checkbox"/> Photo patch test                                 |
| <input type="checkbox"/> Skin patch test (application test)   | <input type="checkbox"/> Total serum IgE concentration (PRIST)            |
| <input type="checkbox"/> Adrenal stress index   | <input type="checkbox"/> Applied kinesiology                              |
| <input type="checkbox"/> Chemical analysis of body tissue   | <input type="checkbox"/> Conjunctival challenge test                      |
| <input type="checkbox"/> Cytotoxic testing  | <input type="checkbox"/> Electrodermal testing                            |
| <input type="checkbox"/> Environmental cultures and chemicals   | <input type="checkbox"/> Hair analysis                                    |
| <input type="checkbox"/> IgG (RAST or ELISA)  | <input type="checkbox"/> Iridology  |
| <input type="checkbox"/> Leukocyte histamine release test (LHRT)  | <input type="checkbox"/> Live cell analysis                               |
| <input type="checkbox"/> Lymphocyte subset counts   | <input type="checkbox"/> Nasal challenge test                             |
| <input type="checkbox"/> Passive transfer, Prausnitz-Kustner test   | <input type="checkbox"/> Provocative-neutralization testing (Rinkel Test) |
| <input type="checkbox"/> Pulse test   | <input type="checkbox"/> Rebeck skin window test                          |
| <input type="checkbox"/> Oral ingestion challenge tests (double blind food challenge)   |   |
| <input type="checkbox"/> In Vitro IgE antibody tests (ELISA, FAST, MAST, RAST)  |   |
| <input type="checkbox"/> Drug provocation test to diagnose suspected IGE-mediated hypersensitivity  |   |
| <input type="checkbox"/> Sequential and incremental testing, (also called intradermal dilutional testing [IDT] and skin endpoint titration [SET] when there is potential for the specific allergen in question to produce an anaphylactic or other life threatening reaction [for example, insect venoms or antibiotics]) |   |
| <input type="checkbox"/> SAGE allergy test for food "delayed sensitivity"   |   |
| <input type="checkbox"/> Blood, red cell, urine or stool micronutrients or trace mineral analysis   |   |
| <input type="checkbox"/> Other: _____   |   |

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This request is being submitted:

- Pre-Claim  
 Post-Claim. If checked, please attach the claim or indicate the claim number: \_\_\_\_\_

- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

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Name and Title of Provider or Provider Representative  
Completing Form (Please Print)\*

Date

**\* The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**