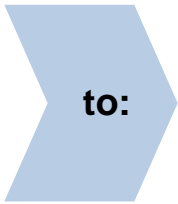


# Allergy Testing and Immunotherapy

**Fax or mail this  
completed form**



**For Pre-Service: Statewide Fax (877) 219-9448**

**For Medicare Advantage (BlueMedicare) HMO and PPO Plans: Fax (904) 301-1614**

**For Post-Service Claims:**

**Florida Blue  
P.O. Box 1798  
Jacksonville, FL 32231-0014**

## Section A

<b>Physician Information/ Requesting Provider</b>	Name:	BCBSF No:	National Provider Identifier (NPI):
	Contact Name:		Phone:
<b>Facility Information/ Location where services will be rendered</b>	Name:	BCBSF No:	National Provider Identifier (NPI):
	Contact Name:		Phone:
<b>Member Information</b>	Last Name:		First Name:
	Member/Contract Number (alpha and numeric):		Date of Birth:
<b>Procedure Information</b>	Procedure Code(s)/Number of Units:		Procedure Description:
	Diagnosis code(s):		Diagnosis Description:
	Date of Service/Tentative Date:		

## Section B

**Medical Necessity:** For detailed information on the criteria that meet the definition of medical necessity for allergy testing, visit the Florida Blue Medical Coverage Guideline website at <http://mcgs.bcbsfl.com>. Refer to Medical Coverage Guideline 01-95000-01, Allergy Testing and Immunotherapy.

## Section C

**Answer ALL of the following questions and check any boxes that apply:**

Yes     No    Are **ANY** of the following procedures being performed for allergy testing? Check all that apply:

- Allergen specific IgG or IgG subclass measurement (any allergen)
- Alpha gal allergy (meat allergy) testing
- Antigen leukocyte cellular antibody (ALCAT) automated food allergy testing
- Basophil activation test (BAT)
- Candidiasis test (serum, saliva, stool)
- Chlorinated pesticides (serum)
- Chronic urticaria index testing
- Complement antigen testing (total or components)
- Cytokine and cytokine receptor assay
- Cytotoxic testing for food, environmental or clinical ecological allergy testing
- Electrodermal testing or electrodermal acupuncture

- Food immune complex assay (FICA)
- Food specific IgG antibodies
- Hair analysis
- Idiopathic environmental intolerance lab tests to affirm the diagnosis of idiopathic environmental intolerance
- Ingestion challenge food testing for diagnosing rheumatoid arthritis, depression, or respiratory disorders not associated with anaphylaxis or similar systemic reactions
- Intracutaneous and subcutaneous provocative and neutralization testing for food allergies
- Iridology
- Leukocyte antibodies testing
- Lymphocyte subset counts
- Lymphocyte function assay
- Mediator release test (MRT); LEAP Program; Mediator Release Test (MRT)
- Muscle strength testing or measurement (kinesiology) after allergen ingestion
- Nutritional assessments, including intracellular analysis of micronutrients
- Prausnitz-Kustner or P-K testing (passive cutaneous transfer test)
- SAGE testing for food delayed sensitivity
- Sublingual provocative testing for food allergies
- Urine autoinjection (autogenous urine immunization)
- Routine allergy re-testing
- Environmental therapy, idiopathic environmental intolerance or clinical ecology treatment, which may include:
  - Aerobic exercise therapy
  - Alteration of the patient's household environment
  - Avoidance therapy
  - Elimination diet
  - Environmental care units
  - IVIG
  - Massages
  - Neutralizing therapy of chemical and food extracts
  - Nutritional therapy
  - Physical therapy
  - Rotation diets
  - Vaccine therapy

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are <b>ANY</b> of the following procedures being performed for the purpose of establishing a diagnosis of allergic disease? Check all that apply:
		<input type="checkbox"/> Direct nasal mucous membrane test
		<input type="checkbox"/> Ingestion challenge test (excluding ingestion challenge testing for diagnosis of rheumatoid arthritis, depression, or respiratory disorders)
		<input type="checkbox"/> Inhalation bronchial challenge testing with histamine, methacholine or similar compounds [Specify compound(s)]:
		<input type="checkbox"/> Intracutaneous (intradermal) tests, sequential and incremental with drugs, biologicals or venoms, immediate type reaction
		<input type="checkbox"/> Intracutaneous (intradermal) tests, sequential and incremental with drugs, with allergenic extracts for airborne allergens, immediate type reaction
		<input type="checkbox"/> Intracutaneous (intradermal) tests with allergenic extracts (allergen vaccine), immediate type reaction (i.e., serial endpoint titration/SET)

<input type="checkbox"/>	Intracutaneous (intra-dermal) tests with allergenic extracts (allergen vaccine), delayed type reaction, including reading
<input type="checkbox"/>	Ophthalmic mucous membrane test
<input type="checkbox"/>	Patch (application) tests with any membrane
<input type="checkbox"/>	Percutaneous (scratch, puncture, prick) tests with allergenic extracts (allergen vaccine), immediate type reaction
<input type="checkbox"/>	Percutaneous (scratch, puncture, prick) tests sequential and incremental, with drugs, biologicals or venoms, immediate type reaction
<input type="checkbox"/>	Photopatch tests
<input type="checkbox"/>	Photo tests
<input type="checkbox"/>	Provocative testing (e.g., Rinkel test)
<input type="checkbox"/>	In vitro testing for allergen specific IgE, which includes: <ul style="list-style-type: none"> <li>• ELISA (enzyme linked immunosorbent assay)</li> <li>• FAST (Fluorescent allergosorbent test)</li> <li>• IP (Immuno-peroxidase test)</li> <li>• MAST (Multiple thread allergosorbent test)</li> <li>• RAST (Radioallergosorbent test)</li> <li>• PRIST (Paper radioimmunosorbent test)</li> <li>• CAP assay</li> </ul>

Yes     No    Is the test being performed by or under the direct supervision of a physician?

**Additional Comments:**

**Section D – Medicare Members**

**Answer the following question for Medicare Advantage Members only:**

Yes     No    Is the test being performed sublingual intracutaneous and subcutaneous provocative and neutralization testing and neutralization therapy for food allergies?

**Additional Comments:**

I hereby certify that (i) I am the treating physician for above member, (ii) the information contained in and included with this Certificate of Medical Necessity is true, accurate and complete to the best of my knowledge and belief, (iii) the member's medical records contain all appropriate documentation necessary to substantiate this information. I acknowledge that a determination made based upon this Certificate of Medical Necessity is not necessarily a guarantee of payment and that payment remains subject to application of the provisions of the member's health benefit plan, including eligibility and plan benefits. Additionally, I further acknowledge and agree that Florida Blue may audit or review the underlying medical records at any time and that failure to comply with such request may be a basis for the denial of a claim associated with such services.

Ordering Physician's Signature:	Date:
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