Phone: 740-455-5199

Authorization Request: Outpatient
Physical-Occupational-Speech Therapies

Please Fax Request to: (740) 455-8817

Today's Date: ___________________

Member Information

Member Name: ____DOB: _________________________

Member ID#: ___________________________ Employer: ________________________________

Ordering Physician Information

Physician Name: ________________________________Phone/Fax #: _________________/________________

Physician Address: ____ Date of Service: ________________________

Physician Tax ID/NPI: _____________________________ Office Contact Person: _____________________________

Facility Information

Facility Name: ___________________________________ Facility Tax ID/NPI: _____________________________

Facility Address: _________________________________ Facility Phone/Fax #: ____________________________

Initial Requests

Service Requested: PT _____ OT _____ ST _____ Start Date: _____________________________

Date of Onset Acute Pain: ___________________

Diagnosis: ________________________________ Diagnosis Code: ________________________________

CPT Code(s) ____

Treatment Plan w/ Frequency and Goals: ____

____

Workers Comp or MVA Related: Y _____ N _____

Continued Treatment Requests

Is member showing progression? Y _____ N _____

Any change in original plan of treatment? Y _____ N _____