

Authorization Request for ADDITIONAL PT/OT SERVICES



Complete and submit this form by fax to 877-548-1547

PATIENT INFORMATION			
Last Name: <input style="width: 95%;" type="text"/>	First Name: <input style="width: 95%;" type="text"/>	Sponsor's SSN <input style="width: 95%;" type="text"/>	Sponsor's Name <input style="width: 95%;" type="text"/>
Address <input style="width: 95%; height: 40px;" type="text"/>		DOB: <input style="width: 95%;" type="text"/>	Phone Number: <input style="width: 95%;" type="text"/>
PROVIDER INFORMATION			
Therapist Name <input style="width: 95%;" type="text"/>	Facility Address <input style="width: 95%; height: 30px;" type="text"/>		Facility Phone <input style="width: 95%;" type="text"/>
Facility Name <input style="width: 95%;" type="text"/>	Facility Tax ID <input style="width: 95%;" type="text"/>		Facility Fax <input style="width: 95%;" type="text"/>
SUBJECTIVE COMPLAINTS AT THE INITIAL VISIT AND MOST RECENT RE-EVALUATION <input style="width: 95%; height: 50px;" type="text"/>			
EXAMINATION FINDINGS AT THE INITIAL VISIT AND MOST RECENT RE-EVALUATION <input style="width: 95%; height: 50px;" type="text"/>			
PRESENT GOALS FOR THE PATIENT AND RATIONALE FOR ADDITIONAL CARE <input style="width: 95%; height: 50px;" type="text"/>			
MODALITIES/PROCEDURES <input style="width: 95%; height: 40px;" type="text"/>			Total Episodes of Care Already Administered as of Today <input style="width: 95%;" type="text"/>
1. Anticipated Dates of Care: From - (mm/dd/yyyy) <input style="width: 60px;" type="text"/> To - (mm/dd/yyyy) <input style="width: 60px;" type="text"/> 2. Anticipated Frequency & Duration: <input style="width: 250px;" type="text"/> 3. Patient has been instructed in Home Exercise Program <input type="checkbox"/> YES <input type="checkbox"/> NO 4. Patient's compliance with Home Exercise Program is <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> N/A 5. Significant decrease in the patient's PAIN over last two weeks of therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A 6. Significant increase in the patient's ROM over last two weeks of therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A 7. Significant decrease in FUNCTIONAL IMPAIRMENT over last 2 weeks of therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A 8. Has therapy addressed other joints/body areas not specified in the original authorization? <input type="checkbox"/> YES <input type="checkbox"/> NO			