

# Authorization Request for ADDITIONAL PT/OT SERVICES



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

| PATIENT INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                           |                                                          |                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| Last Name:<br><input style="width:90%;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | First Name:<br><input style="width:90%;" type="text"/>                    | Sponsor's SSN<br><input style="width:90%;" type="text"/> | Sponsor's Name<br><input style="width:90%;" type="text"/>                                                |
| Address<br><input style="width:95%; height: 40px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                           | DOB:<br><input style="width:60%;" type="text"/>          | Phone Number:<br><input style="width:60%;" type="text"/>                                                 |
| PROVIDER INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                           |                                                          |                                                                                                          |
| Therapist Name<br><input style="width:95%;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Facility Address<br><input style="width:95%; height: 30px;" type="text"/> |                                                          | Facility Phone<br><input style="width:90%;" type="text"/>                                                |
| Facility Name<br><input style="width:95%;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Facility Tax ID<br><input style="width:60%;" type="text"/>                |                                                          | Facility Fax<br><input style="width:90%;" type="text"/>                                                  |
| SUBJECTIVE COMPLAINTS AT THE INITIAL VISIT AND MOST RECENT RE-EVALUATION<br><input style="width:95%; height: 60px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                           |                                                          |                                                                                                          |
| EXAMINATION FINDINGS AT THE INITIAL VISIT AND MOST RECENT RE-EVALUATION<br><input style="width:95%; height: 60px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                           |                                                          |                                                                                                          |
| PRESENT GOALS FOR THE PATIENT AND RATIONALE FOR ADDITIONAL CARE<br><input style="width:95%; height: 60px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                           |                                                          |                                                                                                          |
| MODALITIES/PROCEDURES<br><input style="width:95%; height: 50px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                           |                                                          | Total Episodes of Care<br>Already Administered<br>as of Today<br><input style="width:80%;" 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"/><br>2. Anticipated Frequency & Duration: <input style="width:300px;" type="text"/><br>3. Patient has been instructed in Home Exercise Program <span style="float:right"><input type="checkbox"/> YES <input type="checkbox"/> NO</span><br>4. Patient's compliance with Home Exercise Program is <span style="float:right"><input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> N/A</span><br>5. Significant decrease in the patient's PAIN over last two weeks of therapy? <span style="float:right"><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</span><br>6. Significant increase in the patient's ROM over last two weeks of therapy? <span style="float:right"><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</span><br>7. Significant decrease in FUNCTIONAL IMPAIRMENT over last 2 weeks of therapy? <span style="float:right"><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A</span><br>8. Has therapy addressed other joints/body areas not specified in the original authorization? <span style="float:right"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> |                                                                           |                                                          |                                                                                                          |