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 _____