AUTHORIZATION REQUEST FOR THERAPY SERVICES

Fax to 1-800-685-5231

Home Health Provider Name: _____

Phone Number: _____

Fax from Name: _____

Member Name: _____

Request Type: ☐ New ☐ Ongoing Authorization # _____

For New Request: Please complete the following information:

Member GHP ID: _____

Member Name: _____

Ordering MD: _____

Diagnosis: _____

Reason for Home Health: _____

Home Environment: _____

Family/Support: _____

Therapy Type: ☐ Physical ☐ Occupational ☐ Speech

For ongoing request, please include auth number and name as requested above:

Therapy Type: ☐ Physical ☐ Occupational ☐ Speech

<u>Number of Visits Requested and Timeframe</u>

Physical Therapy Number of Visits: _____ Start Date: _____ End Date: _____

Occupational Therapy Number of Visits: _____ Start Date: _____ End Date: _____

Speech Therapy Number of Visits: _____ Start Date_____ End Date: _____

Physical Therapy Date: Present Status

ACTIVITY	INDEPENDENT	SUPERVISION	CONTACT GUARD	MIN	MAX
Ambulation/ Distance					
Functional Transfers					
Stairs					
Wheelchair Maneuvering					

Goals for Physical Therapy Visits:

ACTIVITY	INDEPENDENT	SUPERVISION	CONTACT GUARD	MIN	MAX
Ambulation/ Distance					
Functional Transfers					
Stairs					
Wheelchair Maneuvering					

Occupational Therapy Assistive Devices Presently Being Used:

_____

_____

_____

Present Occupational Functions:

ACTIVITY	INDEPENDENT	SUPERVISION	CONTACT GUARD	MIN	MAX
Upper Body Hygiene					
Upper Body Dressing					
Lower Body Dressing					
Shower/or Tub Transfers					
Functional Transfers					
Meal Prep					
Other					

Goals for Occupational Therapy Visits:

ACTIVITY	INDEPENDENT	SUPERVISION	CONTACT GUARD	MIN	MAX
Upper Body Hygiene					
Upper Body Dressing					
Lower Body Dressing					
Shower/or Tub Transfers					
Functional Transfers					
Meal Prep					
Other					

Speech Evaluation:

_____

_____

_____

GOALS for Speech Visits:

_____

_____

_____