



Therapy Prior Authorization Request Form
MEDICAL RECORDS ARE REQUIRED WITH THIS FORM
 Documentation must be uploaded thru the Provider Portal

Service Type (check one only*): Physical Therapy (PT)
 Occupational Therapy (OT)
 Speech (ST)

Separate authorization requests are required for each Type of Service.

MEMBER INFORMATION:																																																							
Name: _____	Date of Birth: _____																																																						
ID Number: _____	Male: <input type="checkbox"/> Female: <input type="checkbox"/>																																																						
REFERRING PROVIDER:	RENDERING PROVIDER:																																																						
Name: _____	Name: _____																																																						
NPI: _____	Office Contact: _____																																																						
OHCA ID: _____	NPI: _____																																																						
Phone: _____ Fax: _____	OHCA ID: _____																																																						
Address: _____	Phone: _____ Fax: _____																																																						
Address: _____	Address: _____																																																						
DIAGNOSES: Code _____, Code _____, Code _____, Code _____																																																							
REQUESTED SERVICE INFORMATION:																																																							
For Speech, what primary language is spoken by patient in home setting? _____																																																							
Can speech therapist evaluate and treat in patient's primary spoken language? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																							
Have you previously serviced this member? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																							
If Yes: How many units previously approved? _____ How many units Used? _____																																																							
REQUESTED SERVICES:																																																							
Requested Date Span: From _____ To _____																																																							
Anticipated Number of Visits: _____ Duration of Session (in minutes): _____																																																							
	<table border="0" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;"></th> <th style="width:20%;">CODE</th> <th style="width:20%;">UNITS</th> <th style="width:20%;">MODIFIERS</th> <th style="width:20%;"></th> <th style="width:20%;"></th> </tr> </thead> <tbody> <tr> <td>A.</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>B.</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>C.</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>D.</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>E.</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>F.</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>G.</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>H.</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		CODE	UNITS	MODIFIERS			A.	_____	_____	_____	_____	_____	B.	_____	_____	_____	_____	_____	C.	_____	_____	_____	_____	_____	D.	_____	_____	_____	_____	_____	E.	_____	_____	_____	_____	_____	F.	_____	_____	_____	_____	_____	G.	_____	_____	_____	_____	_____	H.	_____	_____	_____	_____	_____
	CODE	UNITS	MODIFIERS																																																				
A.	_____	_____	_____	_____	_____																																																		
B.	_____	_____	_____	_____	_____																																																		
C.	_____	_____	_____	_____	_____																																																		
D.	_____	_____	_____	_____	_____																																																		
E.	_____	_____	_____	_____	_____																																																		
F.	_____	_____	_____	_____	_____																																																		
G.	_____	_____	_____	_____	_____																																																		
H.	_____	_____	_____	_____	_____																																																		
Submission of this form, without complete medical records will limit the ability to administer prior authorizations and may result in a cancellation/denial. Please include the following: 1) Evaluation 2) Parental Consent Form SC-15 3) Signed and dated provider prescription/order 4) Change of Provider Form SC-16 if applicable																																																							