OUTPATIENT THERAPY REQUEST FORM

For Medicaid, CHP, Market Plus, Exchange, and MetroPlus Gold members please fax this form along with supporting clinical documentation to (212) 908-3730.

For Medicare members please fax this form along with supporting clinical documentation to (212) 908-4401.

For help with questions please contact us at (800) 303-9626.

Authorization/Tracking #:	E-Power Cert #: (if applicable)

REQUEST TYPE		
☐ **Preauthorization:** New request for services not previously approved, prior to service date	☐ **Concurrent:** Request for additional services for a service previously approved (ongoing care)	☐ **Retrospective:** Request for services already rendered without prior authorization
☐ **Standard** • Preauthorization = 3 business days • Concurrent = 1 business day • Retrospective = 30 calendar days	☐ **Expedited:** The expedited review request is subject to denial if there is no documented life-threatening condition or imminent danger to the member's health. If a request to expedite a review is denied, a determination will be made within the standard timeframe. Retrospective reviews are not eligible for expedited review.	

MEMBER INFORMATION		
Name:	ID#:	Date of Birth:
Street Address:		
ICD-10 Diagnosis Codes(s):		

PROVIDER INFORMATION		
Name:		ID#/TIN/NPI:
Street Address:		
Phone Number:	Fax Number:	Contact Name:
Therapy Group Name (if applicable):		ID#/TIN/NPI:

THERAPY TREATMENT INFORMATION				
Date of Initial Evaluation:		Date of Onset of Symptoms/Condition:		
Previous Treatment: ☐PT ☐ OT ☐ ST	# of visits completed to date:	From:	To:	
Date of Re-Evaluation (if applicable):		Date of last MD Order for Therapy:		
Requested Treatment: ☐PT ☐ OT ☐ ST	____ x per week ____ x weeks	From:	To:	# of visits:

PLACE OF SERVICE	
☐ 02 Telehealth- Not in the home ☐ 03 School ☐ 04 Homeless Shelter ☐ 10 Telehealth- In the Home ☐ 11 Office ☐ 12 Home	☐ 13 Assisted Living Facility ☐ 14 Group Home ☐ 19 Off-Campus Outpatient Hospital ☐ 22 On Campus- Outpatient Hospital ☐ 49 Independent Clinic ☐ 50 Federally Qualified Health Ctr

- Requests must be submitted with supporting clinical documentation including: a copy of the initial evaluation, copies of any re-evaluations performed, a copy of the most recent doctor's order, documentation on the member's initial functional status, pain rating, treatment plan and goals, evidence of their progression or regression during the previous treatment period, and the member's status at the end of the treatment period including the current functional status, current pain rating, goals met/not met, and any modifications to the treatment plan. Requests received without this documentation are subject to denial.