Supplemental Information Needed for PT/OT/ST Authorization Requests

This document must be submitted with the standard Outpatient Authorization request form.

MEMBER INFORMATION

Member Name _____ Member ID _____ Member Date of Birth _____

REQUIRED DOCUMENTATION CHECKLIST

- ☐ **CURRENT PLAN OF CARE**: Signed and dated specifying frequency, duration and type of treatment.
- ☐ **CURRENT ASSESSMENT**: Must include measurable objectives (ROM/Strength/Pain, etc.), an evaluation that includes standardized functional assessment results for developmental delay requests, if appropriate, and therapist's observations.
- ☐ **CONTINUATION OF CARE REQUESTS**: Documentation of specific progress toward previous goals and updated/current plan of care.
- ☐ **PRESCRIPTION FOR THERAPY**: Must be signed and dated by physician. Outpatient prescriptions are good for 1 year, EPSDT prescriptions are good for 6 months and Home Health prescriptions are good for 60 days unless limited by the referring provider. Verbal orders, for home health requests only, are valid for 30 days from date of issue.

DIAGNOSIS/DISORDER

Primary Diagnosis (ICD-10) _____ Secondary Diagnosis (ICD-10) _____ Treatment Area/Focus _____

THERAPY SERVICE AUTHORIZATION REQUEST FOR TREATMENT

Service location: ☐ Hospital ☐ Outpatient ☐ Clinic/Rehab ☐ Office ☐ Home

Service	Date Treatment Initially Started	Frequency (Visits seen per month or week)	Total Visits or Units	Start Date	End Date
Speech Therapy		____ x ☐ week or ☐ month			
Physical Therapy		____ x ☐ week or ☐ month			
Occupational Therapy		____ x ☐ week or ☐ month			

INITIAL EVALUATION

Discipline: ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy

Start date for Initial Evaluation _____

Has the member had an initial evaluation previously this year? ☐ Yes ☐ No

If yes, why is another initial evaluation warranted? _____

RE-EVALUATION

Discipline: ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy

Date of Last Evaluation: _____ Authorization Start Date for Re-Evaluation: _____

DISCHARGE PLAN/TRANSITION PLAN

Anticipated discharge date: _____

Plan to transition to home program: _____