



THERAPY AUTHORIZATION

DATE: _____

Instructions: Type or print clearly.

1. Member Name:	2. Member ID Number:
3. Billing Provider – Name and Address (City, State, Zip Code):	3b. Billing Provider Telephone Number: () -
3a. Provider ID Number: _____	3c. Billing Provider Fax Number: () -

4. ICD-9 Diagnosis, Clinical Information:

Service Requested	Date Range of Visits (i.e. 1/1/06 – 2/15/06)	# of Requested Units / # of Weeks	Total # of Units
PT			
OT			
ST			

PT: Assess/Eval Therapeutic Exercises ADL/Mobility/Transfer Training HEP Strength/ROM
 Other _____

OT: Assess/Eval ADL/Mobility/Transfer Training Teaching HEP Other _____

ST: Assess/Eval Speech Retraining Cognitive Deficit Aspiration Precaution Feeding Training
 Verbal Motor Training Cognitive Sentence Recognition Cognitive Word Finding Other _____

PLEASE ATTACH CURRENT PHYSICIAN PRESCRIPTION. PRESCRIPTION IS VALID FOR 30 DAYS.

Person completing this form: _____

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.