Phone: (682)885-2252 or 1-800-862-2247
Fax: 682-885-8402 or toll free 1-844-643-8402

Therapy Authorization Request Form

Member Name	Last:	First:	Middle:
ID Number		Date of Birth:	
Diagnoses Requiring Therapy:			
ICD-10 Diagnosis Codes:			

Therapy Discipline, Type and Requested Place of Service – Please Check Appropriate Boxes

☐ PT ☐ OT ☐ ST Condition for Therapy ☐ Acute ☐ Chronic	**Place of Service (POS):** ☐ Office (11); ☐ Outpatient Hospital (22); ☐ Home (12); ☐Other _____ (Specify) All requests will be evaluated as to medical necessity/appropriateness - Attach ordering prescribers (PCP/medical home) attestation.

Are the requested therapy services provided through the following programs:	School Health and Related Services (SHARS) ☐ Yes ☐ No	Early Childhood Intervention (ECI) ☐ Yes ☐ No

Date of Therapy Evaluation or Re-evaluation	PT / /	OT / /	ST / /

Attach a copy of the therapy evaluation, re-evaluation, or most recent progress note for each therapy discipline requested.

Discipline and Modifier	Dates of Service		Procedure Code(s) Requested	Frequency per Week	Total Requested ☐ Units ☐ Visits
	From	Through			
PT (GP)	/ /	/ /			
OT (GO)	/ /	/ /			
ST (GN)	/ /	/ /			

Prescribing physician signature/attestation is required on this form unless one of the following is attached to this request:
New Evaluation - A legible, signed and dated prescription or written order by the attending physician
Treatment Plan or Continued Therapy Requests - Prescribing physician's review and signature/date on the recommended treatment plan.

	Printed Name	**Signature & Medical Necessity Attestation**	**Date of Signature**
Physical Therapist			/ /
Occupational Therapist			/ /
Speech Therapist			/ /
Prescribing Physician			/ /

Prescribing Physician NPI and License Number		Date Member Last Seen by Prescribing Physician: / /

Therapy Billing Provider Information

Therapist or Company Name (Service/Billing Provider):	Telephone:
Address"	Fax:
For STAR Members - TPI (Service/Billing Provider):	For CHIP Members - NPI (Service/Billing Provider):

(PLEASE DO NOT WRITE BELOW THIS LINE.)

☐Approved ☐Denied ☐Partial Denial Effective Date: From___/___/___ To___/___/___

Authorization Number:_____

Authorization is a condition of reimbursement and is not a guarantee of payment. Payment of a claim is subject to a member's eligibility at the time services are provided and to the contractual limitations, provisions, and exclusions of the member's benefit plan.