THERAPY NETWORK OF PUERTO RICO

PATIENT INTAKE FORM

Fax this request to 1-800-615-0148. This form must be filled out in its entirety.
For inquiries or status of pending requests, call: 1-877-614-5056 or visit the Provider Web Portal

☐ Routine ☐ Urgent (please indicate Medical reason in Note/Comments below)

PLEASE SUBMIT ONE FORM PER DISCIPLINE

Member ID Number	Member Health Plan	Member County
Member Last Name	Member First Name	Member Telephone Number
Member Date of Birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Request Date (mm/dd/yyyy)
Referring Provider Last Name	Referring Provider First Name	Referring Provider NPI
Referring Provider Phone Number	Fax Number (Required for Fax Notifications)	Contact Person
Facility/Group Name		TIN Number
Facility/Group Address (for/from services will be rendered)		Facility/Group NPI
City		State / Zip Code
Treating Therapist Last Name (rendering)	Treating Therapist First Name (rendering)	Treating Therapist (rendering) NPI
Line of Business ☐ Medicare	Place of Service ☐ Office (11) ☐ Independent Clinic (49)) ☐ Home (12) ☐ Other [__ __]	

Primary Diagnosis Description

ICD Code 1	ICD Code 2	ICD Code 3	ICD Code 4

If Status Post Surgery, List Procedure

Date of Surgery (mm/dd/yyyy)	For Cerebral Vascular Accident (CVA), list Date of CVA (mm/dd/yyyy)

☐ Please check box to confirm Member's Plan of Care has been submitted and approved by ordering Provider and the frequency and duration are: _____ times/ per week _____ number of weeks	☐ Please check box to confirm The servicing provider has reviewed the approved Plan of Care with the Enrollee, including the frequency and duration, and will provide these services.	☐ Please check box to confirm Ordering Provider will be notified when therapy has been completed and whether the goals have been achieved (Member discharged) or Therapy was stopped.

FILL OUT SEPARATE PATIENT INTAKE FORM FOR EACH DISCIPLINE

☐ Physical ☐ Occupational ☐ Speech ☐ Vestibular ☐ Lymphedema ☐ *Physiatry	Evaluation Date (mm/dd/yyyy):
Test Used (Attach Test Scores)	Test score (attach test scores)

Note/Comments

I, the undersigned, hereby attest that the information provided above is accurate and truthful to the best of my knowledge and belief.

Provider or Authorized Representative Signature _____ Print Name _____ Date _____

*For Physiatry Only: Indicate CPT codes requested