



Patient Intake Form

Fax this request to 1-800-615-0148

Routine **Urgent** (An expedited/urgent request is only warranted when applying the standard timeframe for making a determination could seriously jeopardize the enrollee's health, life, or ability to regain maximum function)

This form must be filled out in its entirety. For inquiries or status of pending requests, visit the Provider Web Portal. **Please SUBMIT ONE FORM PER DISCIPLINE and include current medical order, evaluation & POC**

Member ID Number		Member Health Plan		Request Date (mm/dd/yyyy)	
Member Last Name			Member First Name		
Member Telephone Number		Member Date of Birth (mm/dd/yyyy)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Referring Provider Name		Phone Number	Fax Number		Referring Provider NPI
Facility/Group Name (Rendering Provider)				Facility/Group TIN Number	
Facility/Group Address				Facility/Group NPI	
City		Zip Code	Contact Person Name		
Phone Number			Fax Number (Required for Fax Notifications)		
Treating Therapist Last Name		Treating Therapist First Name		Treating Therapist NPI	
Line of Business: <input type="checkbox"/> Medicare		Place of Service: <input type="checkbox"/> Office (11) <input type="checkbox"/> Home (12) <input type="checkbox"/> Outpatient Hosp. (22) <input type="checkbox"/> Independent Clinic (49) <input type="checkbox"/> Other [__ _]			

Primary Diagnosis Description:

ICD Code(s)		CPT Code(s)	
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If Status Post Surgery, List Procedure

Date of Surgery (mm/dd/yyyy)		For Cerebral Vascular Accident (CVA), list Date of CVA (mm/dd/yyyy)	
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<input type="checkbox"/> 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	<input type="checkbox"/> 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.	<input type="checkbox"/> 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.
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FILL OUT SEPARATE PATIENT INTAKE FORM FOR EACH DISCIPLINE

<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Aquatic Therapy <input type="checkbox"/> Vestibular <input type="checkbox"/> Lymphedema* * For Lymphedema Only: CPT codes, Frequency and Units Required. (This information needs to be added in the Note/Comments Section)		Evaluation Date (mm/dd/yyyy):	<input type="checkbox"/> Initial Review (1 st Episode) <input type="checkbox"/> Episode Number (2 nd , 3 rd , 4 th , etc): _____ <input type="checkbox"/> Previous Eval Dates: _____
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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
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