

OUTPATIENT PREAPPROVAL FOR THERAPIES

For Assistance, please contact us at:

Phone 800-444-5769

Fax (952) 896-1261

___ PT ___ OT ___ Speech

___ Initial Request ___ Additional Visits Request

Date _____

Provider _____

Address _____
(Street) (City) (State) (Zip)

Tax ID Number _____ Telephone # _____

Policy Holder _____ ID# _____

Patient _____ DOB _____

Address _____

Diagnosis Code _____ Description _____

Procedure Codes

CPT code: _____ CPT code: _____ CPT code: _____

CPT code: _____ CPT code: _____ CPT code: _____

HCPC code: _____ HCPC code: _____ HCPC code: _____

Therapist _____ Referring physician _____

First date of service _____ # Visits requested _____ Previous Auth # _____

Frequency and duration

History and Symptoms

How did this problem occur?

_____ Onset date _____

Outpatient Pre-approval
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Past history (including previous chiro/med care, if surgery what kind?) _____

Functional physical Assessment:

Baseline measurable status:

Baseline functional status:

Rehab potential _____

Home treatment program

Date initiated _____

_____ Patient does understand diagnosis and prognosis well

_____ Patient does not understand diagnosis and prognosis well

Contraindications to treatment or complicating factors:

FOR PROMPT REVIEW, PLEASE HAVE ALL QUESTIONS ANSWERED.