

OUTPATIENT TREATMENT REQUEST (OTR)

Specialty Therapy & Rehab Services

Please write clearly and only in designated areas. Authorization cannot be provided unless ALL requested information is included.

REQUIRED DOCUMENTATION CHECKLIST

- CURRENT PLAN OF CARE:** Signed and dated specifying frequency, duration and type of treatment.
- CURRENT ASSESSMENT:** Must include measurable objectives (ROM/Strength/Pain, etc.), an evaluation that includes standardized functional assessment results for developmental delay requests, if appropriate, and therapist's observations.
- CONTINUATION OF CARE REQUESTS:** Documentation of specific progress toward previous goals and updated/current plan of care.
- PRESCRIPTION FOR THERAPY:** Must be signed and dated by physician. Outpatient prescriptions are good for 1 year, EPSDT prescriptions are good for 6 months and Home Health prescriptions are good for 60 days unless limited by the referring provider. Verbal orders, for home health requests only, are valid for 30 days from date of issue.

MEMBER INFORMATION

Member ID # _____

Date of Birth _____

First Name _____

Last Name _____

Address/City/State/Zip Code _____

Phone: _____

Does the member have other health insurance? If Yes, please provide:

PROVIDER PERFORMING THE SERVICE

Check GROUP or INDIVIDUAL to indicate how to authorize.

Group Individual

Group/Facility Name _____

Individual Rendering Provider Name _____

Address/City/State/Zip Code _____

Provider Phone _____

Provider Fax _____

Group/Facility NPI (required) _____

Rendering Provider NPI (required) _____

DIAGNOSIS/DISORDER

Please indicate ICD-10 code(s)

Primary Diagnosis: _____

Secondary Diagnosis: _____

Treatment Area/Focus: _____

Tax ID (required) _____

Contact Name _____

Contact Phone _____

EARLY SUPPORTS AND SERVICES (ESS)

This section is to address IDEA (Individuals with Disabilities Education Act) Birth to Three Program Services (Part C) being delivered to address developmental delays.

Is this member receiving ESS services? Yes No

Is the service being requested an ESS service? Yes No

If yes, refer to state guidance for authorization procedures.

PRESCRIBING PROVIDER

Prescribing Provider Name _____

Phone _____

Fax _____

THERAPY SERVICE AUTHORIZATION REQUEST FOR TREATMENT

Service Location: Hospital-Outpatient Clinic/Rehab Center Office Home

| Service | Date Treatment Initially Started | Frequency (Visits seen per month or week) | Total Visits or Units Requested | Requested Start Date for Treatment | Requested End Date for Treatment |
|----------------------|----------------------------------|---|---------------------------------|------------------------------------|----------------------------------|
| Speech Therapy | | _____ x <input type="checkbox"/> week or <input type="checkbox"/> month | | | |
| Physical Therapy | | _____ x <input type="checkbox"/> week or <input type="checkbox"/> month | | | |
| Occupational Therapy | | _____ x <input type="checkbox"/> week or <input type="checkbox"/> month | | | |

INITIAL AND RE-EVALUATION REQUESTS

(For PAR providers, one eval and one re-eval are allowed per year without authorization. For Non-PAR providers, all eval requests require prior authorization)

Did Evaluation and Treatment occur on the same day?

Yes No

Service Location/Type:

Hospital-Outpatient Clinic/Rehab Center Office Home

Did the member have surgery recently (less than two weeks)?

Yes No

INITIAL EVALUATION

Discipline: Speech Therapy Occupational Therapy Physical Therapy

Start date for Initial Evaluation: _____

Has the member had an intitial evaluation previously this year? Yes No

If yes, why is another initial evaluation warranted? _____

RE-EVALUATION

Discipline: Speech Therapy Occupational Therapy Physical Therapy

Date of Last Evaluation: _____ Authorization Start Date for Re-Evaluation: _____

URGENT REQUEST- By checking this box, I certify that this is an urgent request for medically necessary treatment, which must be treated within 24 hours.

Signature of Prescribing Provider (ex: MD, APRN, etc.) **(Required)**

If not signed by a Prescribing Provider (ex: MD, APRN, etc.), request will be processed according to standard turnaround time.