HealthPlans
A HARVARD PILGRIM COMPANY

Care Management Services
PO Box 663, Westborough, MA 01581
Phone: 866-325-1550
Fax: 508-756-1382

Outpatient Therapy Services (OT/PT/ST) & Chiropractic Care Authorization Request Form

Provider Name: ______________________ Provider Tax ID#: ______________________

Fax: ______________________ From: ______________________

Phone: ______________________ Ext. ______ Date: ______________________

Re (Patient): ______________________ Member ID#: ______________________

Patient D.O.B.: ______________________ Initial Evaluation Date: ______________________

Dx *(indicate left or right)*: ______________________ ICD-9 ______ Pages *(including cover)*: ______

Service(s) Requested:

TYPE OF THERAPY (*check one; must include evaluation and physician script*)

☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Chiropractic Care

TYPE OF REQUEST (*check one*)

☐ Initial Notification/Authorization
(include evaluation and treatment plan)

☐ Extension Review
(send updated progress note with measureable current objective status and evaluations)

Date of Injury: ______________ Please check if applicable: ☐ MVA ☐ Worker's Compensation

COMMENTS: ______________________

____

____

FOR HEALTH PLANS USE ONLY

CASE #: ______________ **APPROVAL:** FROM ______________ TO ______________

COMMENTS:

____

____

Name / Extension: ______________________

Consideration of this request is based upon current information submitted for review. A case number does not guarantee payment; claims payment is dependent on the patient's eligibility at the time services are rendered, the patient's benefits as stated in the plan document, retrospective review of clinical data, and the required documentation of the service(s) provided.

CONFIDENTIALITY NOTICE

This facsimile transmission is intended only for the addressee named above. It contains information that is privileged, confidential or otherwise protected from use and disclosure. The attached may contain health care information. Health care information is personal and sensitive information relating to a person's health care. It is being faxed to you after appropriate authorization from the individual, or under circumstances that do not require individual authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. If you have received this transmission in error, please notify us by telephone immediately so that we can arrange for retrieval of the document. Re-disclosure without additional individual consent is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

rev. 10/22/2010