

Request for Authorization

PT/OT/ST/Chiro

From		
From:		
Fax:	Phone:	Date:
Member Information		
Last name, first name, middle initial:		
Medicaid ID number:	Date of birth:	
Procedure Information		
Please select ONE of the following:		
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech Therapy
		<input type="checkbox"/> Chiropractor
CPT Code:	ICD10 Code:	No visits/units requested:
Service start:		Service end:
Provider Information		
Group name:		NPI number:
Address, city, state ZIP:		
Contact person:	Fax:	Call back number:
Ordering Provider Information		
Practitioner name:		NPI number:
Address, city, state ZIP:		
Contact person:	Fax:	Call back number:

Fax request form with supporting clinical documentation to **1-866-368-4562**.