Pre-Certification/Pre-Authorization Service Request Outpatient Physical, Occupational and Speech Therapy

Date: _______ Service Type Requested: PT ___ OT___ ST___

Provider Information

Servicing Provider

Name: ___________________________

NPI #: ___________________________

Provider #: ________________________

Address: _________________________

____

Phone: (____)____________________

Fax: (____)______________________

Contact Name/Phone #: ______________

____

Ordering Provider

Name: ______________________________

NPI#: ______________________________

Provider#: ___________________________

Address: ____________________________

____

Phone: (____)________________________

Fax: (____)__________________________

Contact Name/Phone #: ________________

____

Patient Information

Patient Name: __________________________

DOB: _________________________________

Phone: _______________________________

Address: _____________________________

____

Subscriber Name: ____________________

ID #: ______________________________

Group #: ___________________________

Date span for requested services: ___/___/___ to ___/___/___

Number of visits requested: ____ Frequency: __________________________

Diagnosis code(s): ____________________

Are services primarily for the treatment of a mental health diagnosis?

____No ____ Yes (list Mental Health diagnosis)_________________________________

ALL the following information is RECOMMENDED to determine medical necessity:

- **Initial evaluation report with testing results**
- **Plan of care with specific, measurable goals**
- **Progress notes**
- **Discharge summary/plan**

Fax form to: (651)662-7816, or Mail form to:
Integrated Health Management, PO Box 64668, St Paul Minnesota 55164-0668

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