



Prior Authorization Request Form
Outpatient (Physical, Occupational and Speech) Therapy
Date: _____

Mail form to: Health and Wellness Services P.O. Box 179; Duluth, Minnesota 55801-0179
 Fax form to: 1-866-938-9754

Service Type Requested: **PT** **OT** **ST**

Provider Information

Serving Provider:	Ordering Provider:
NPI #:	NPI #:
Provider Number:	Provider Number:
Address:	Address:
Fax:	Fax:
Contact Name/Phone #:	Contact Name/Phone #:

Patient Information

Patient Name:	Subscriber/Enrollee:
DOB:	Group Number:
Address:	Identification Number:
	Phone #

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

If YES list Mental Health diagnosis: _____

- ALL the following information is REQUIRED to determine medical necessity:**
- Initial evaluation report with testing results
 - Plan of care with specific, measurable goals
 - Progress notes
 - Discharge summary/plan