Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payer: Primary:  MC  FC  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary:  MC  FC  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Discipline\*** | **Frequency** | **Start Date** | **End Date** |
| PT Evaluation |  |  |  |
| PT Visits |  |  |  |
| Note: |  | | |
| OT Evaluation |  |  |  |
| OT Visits |  |  |  |
| Note: |  | | |
| ST Evaluation |  |  |  |
| ST Visits |  |  |  |
| Note: |  | | |
| MH/AODA Assessment |  |  |  |
| MH/AODA Sessions |  |  |  |
| Note: |  | | |
| \* **A plan of care for each discipline must be faxed at time of request for services.** | | | |

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| --- |
| Prior authorization of evaluation and first treatment if occurring on the same day is waived if the plan of care for each discipline is submitted with this completed form. IDT staff will confirm authorization for evaluation and treatment within 24 hours via Inclusa’s referral process.  Request for ongoing therapy as identified above will follow Inclusa’s customary authorization process. Provider will receive confirmation of authorization via Inclusa’s referral process however there is no need to bill against the authorization until Medicare coverage ends for these services. Provider will receive phone notification if ongoing treatment is declined by the member or denied by the Inclusa Care Team.  For assistance contact 1-888-544-9353 option 7 or [ACS-SHC-SDS-HomeHealth@inclusa.org](mailto:ACS-SHC-SDS-HomeHealth-Therapy@inclusa.org). |

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