



Therapy Services Authorization Request Form

Please send request form and documentation to: Fax (734) 995-0198/Phone (734) 995-1969

All authorizations will be found on the website within 24 hours of receipt of completed request

Today's Date: _____ Requesting: ☐ OT ☐ PT ☐ ST

Member Name: _____ Member's THC ID #: _____

Requested By: _____ Provider ID #: _____

Provider Name: _____

Phone: _____ Fax: _____

Evaluation Date: _____ Evaluation Authorized: ☐ Yes ☐ No

Start Date: _____ End date: _____

Total Visits Requested: _____ Dx Code: _____ Diagnosis: _____

Please check off the requested HCPCS below and list the number of units per visit requested:

<input type="checkbox"/> 97110 _____ units/visit Ther Ex	<input type="checkbox"/> 97112 _____ units/visit Neuro Reed	<input type="checkbox"/> 97140 _____ units/visit Manual Ther
<input type="checkbox"/> 92507 _____ units/visit Speech Ther	<input type="checkbox"/> 97530 _____ units/visit Ther Act	<input type="checkbox"/> 97535 _____ units/visit Self Care
<input type="checkbox"/> 97018 _____ units/visit Paraffin bath	<input type="checkbox"/> 97035 _____ units/visit Ultrasound	<input type="checkbox"/> 97012 _____ units/visit Mechanical traction
<input type="checkbox"/> 97014 _____ units/visit E-stim (unattended)	<input type="checkbox"/> 97032 _____ units/visit E-stim (manual)	<input type="checkbox"/> 97760 _____ units/visit Pros/Orthotics

Comments:

Auto Accident related? ☐ Yes ☐ No Insurance Co: _____

Claim #: _____ Adjuster: _____

Work Related? ☐ Yes ☐ No

OFFICE USE ONLY

Authorization #	Entered Date	# of Visits	History
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments:

PLEASE NOTE: The number of VISITS that are authorized will be noted in the COMMENTS section of the Authorization. Thank you

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