61463

healthfirst

PT/OT Prior Authorization Request Form

Please fax to OrthoNet at: 1-844-888-2823

Fax Date: _____ # of Pages Faxed: _____

PATIENT INFORMATION:

Healthfirst Member ID Number

OR

Medicaid Member ID Number

First Name

Last Name

Date of Birth Month / Day / Year

THERAPY PROVIDER INFORMATION:

Facility or Provider Name

PROHEALTH AND FITNESS

Street Address

180 WEST END AVE, APT 1M

City

NEW YORK

State NY

ZIP 10023

Telephone Number

(212) 600-4781

Fax Number

(800) 655-3780

The above fax number will be used to confirm your address/location if we are unable to contact you using the fax number on file with Healthfirst

Healthfirst Provider ID

National Provider Identifier (NPI)

1124346450

◉ Facility NPI Number ○ Individual NPI Number

Provider Tax ID Number

271313898

◉ Facility TIN Number ○ Individual TIN Number

REQUEST INFORMATION:

Request for:

- ○ Onset (Commencement) of Therapy Services
- ○ Extension of Therapy Services
- ○ Existing case, new injury or condition
- ○ Existing case, new episode or recurrence

Therapy Visits to Date for this condition:

Initial Evaluation Date Month / Day / Year

Date of Last Therapy Visit Month / Day / Year

Service Type:

- ○ Physical Therapy
- ○ Occupational Therapy

Setting:

- ○ Office
- ○ Outpatient Hospital
- ○ Telehealth

Instructions:

1. Use this form when requesting prior authorization of therapy services for Healthfirst members.
2. **Please complete and Fax this request form along with all supporting clinical documentation to OrthoNet at 1-844-888-2823.** (This completed form should be page 1 of the Fax.)
3. Please ensure that this form is a DIRECT COPY from the MASTER.
4. Please PRINT, in black ink, one character per box for ALL requested information and completely fill in each circle for selection where applicable.
5. For assistance in completing this form, please call OrthoNet provider services toll free at 1-844-641-5629.

NOTE: The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material/information in error, please contact the sender and delete or destroy the material/information.

For Internal Office Use Only

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Healthfirst Member ID Number

* ***Note:*** ***The above Member ID number MUST be Identical to the Member ID number provided on Page 1 of this form.)***

REQUEST INFORMATION

Condition Type: O Acute (less than 2 months) O Sub-acute (2-3 months) O Chronic (more than 3 months)

Primary Diagnosis Code | | | | . | | | | | (ICD-10 Format)

Affected Region: O Right O Left O Bilateral O Not Applicable

Onset: O Insidious/No Trauma O Traumatic Injury O Repetitive Stress O Post-Operative
O Work-related O Motor Vehicle

For Post-Operative Cases Only:

Type of Surgery: O Joint Replacement O ACL Reconstruction O Rotator Cuff/Labral Repair O Spinal Fusion
O Arthroscopy O Tendon Repair O Other: _____

Date of Surgery

		/			/				
Month			Day			Year			

Chief Complaint(s):
O Pain O Stiffness O Weakness
O Loss of Balance O Decreased/Loss of Function
O Other: _____

Pain Intensity (0-10): | | Last 24 hours | | | Past Week

Frequency of Symptoms:
O Constant O Frequent O Occasional O Intermittent

Impact of Symptoms on ADL:
O None O Minimal O Moderate O Significant

Muscle Strength (MMT): O 5/5 O 4/5 O 4-/5 O 3+/5 O 3/5 O 3-/5 O 2+/5 O 2/5 O 1/5 O 0/5

Active Range of Motion Limitations: O None O Minimal O Moderate O Significant

Functional Limitations: O None O Minimal O Moderate O Significant

Functional Measure Score (For Chief Complaint): | | | | Most Recent Score

Form Type: O Neck O Back O SF 12/36
O LEFS O DASH O KSS
O Other: _____

Progress since first visit: O None, first visit O No Progress Yet O Some Progress O Significant Progress
O Significantly Worse

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