MetroPlusHealth

METROPLUS.ORG 1.800.303.9626

OUTPATIENT THERAPY AND CHIROPRACTIC SERVICES REQUEST FORM

All lines of business including Medicaid, Medicare, Essential, Commercial

Please complete the form in its entirety and return it by fax to 212.908.3730 with clinical supporting documentation including any initial evaluations or re-evaluations that were performed. For general questions call 800.303.9626.

REQUEST TYPE							
☐	Physical Therapy	☐	Occupational Therapy	☐	Speech Therapy	☐	Chiropractic Services (Only covered for Essential Plan 1-4, Medicare and Commercial plans)
☐	Preauthorization (First request for approval of services)	☐	Concurrent Request (Request for approval of additional services)	☐	Retrospective Request (Request for services already rendered)	☐	Request for change to an existing approval
☐	**Standard Review** Turnaround Time: Preauthorization= 3 business days, Concurrent= 1 business day and Retrospective= 30 calendar days	☐	**Expedited Review** (Life-threatening or imminent danger to the member, subject to medical necessity and may be denied) Turnaround Time: 72 hours if expedited is honored, if expedited is denied processed as preauthorization= 3 business days.				
Date of Request:		Number of pages of clinical documentation attached:					

MEMBER INFORMATION	
Member ID:	Full Name:
Date of Birth:	Address:
ICD-10 Diagnosis(es):	
Date of Injury (if applicable):	Date of Surgery (if applicable):

PROVIDER INFORMATION	
Full Name:	Tax ID or NPI:
Phone Number:	Fax Number:
Servicing Address:	
Contact Name:	Direct Phone/Ext:

PREVIOUS TREATMENT	
Date of Initial Evaluation:	Date of Re-Evaluation:
Number of Visits Completed to Date:	Previous Dates of Service From: To:

TREATMENT PLAN	
Continue Therapy: _____ times per week x _____ weeks	HEP in place and being followed? ☐ Yes ☐ No
Number of Visits Requested:	Requested Dates of Service From: To:

Comments: _____

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