

Patient Intake Form

Please Fax To Therapy Network

Authorization Department: (855) 825-7820 Phone Inquiries: (855) 825-7818

General										
Date of Request Type of Service Place of Service										
		t (Medically nec	essary wit	hin 72	hour	s)	Office	Out	Pt. Hospital	
Submit separate Form for each PT OT	type ST	Other:								
Member Information										
Member Name: (Last, First, M)	irst, M)			Date of Birth			Mei	Member ID		
Street Address		City			ST	Zip	Pho	ne		
PCP										
Ordering Provider Name (PCP)				Ordering PCP Phone			ne Ord	e Ordering PCP Fax		
Therapy Provider Informa	tion		·							
Are you currently contracted v	vith TNNJ? Indiv	vidual Treating P	rovider N	ame						
Yes No										
Therapy Facility Name	,									
Phone Number	Fax Number		NPI				Tax ID #			
Street Address		Cit	.y					ST	Zip	
Required Information										
Diagnosis Treatment				ICD-10 Codes						
Other Info: (e.g. surgery, list pr	ocedure and date	of surgery)								
Date of Evaluation	on Plan of Treatment									
For school aged children, submit IEP, or reason for non-availability of IEI				Number Visits Completed				Date of Last Visit		
I, the undersigned, hereby attest that the information provided above is accurate and truthful to the best of my knowledge and belief.										
Provider or Authorized Representative Signature					Print Name				Date	

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