

OCCUPATIONAL THERAPY REQUEST

- This information is private and confidential.
- Please complete all information on this form.

Therapist: _____ Date: _____
 Mailing Address: _____ City, State, Zip: _____
 Contact Person: _____ Fax: _____
 Phone # : _____ Referring Physician: _____
 Patient: _____ DOB: _____
 Member: _____ Member ID #: _____

Summary Progress Towards Current OT Goals: _____

New Goals: _____

TREATMENTS

Initial Evaluation: _____ Total # Additional Treatments Requested: _____
 2nd Evaluation: _____ Frequency of Treatments Requested: _____
 Total # Treatments To Date This Calendar Year: _____ Beginning Date for Additional Treatments: _____
 Ending Date for Additional Treatments: _____

*****FOR HEALTHCHOICE USE ONLY (Do Not Write Below This Line)*****

Extension #1	<u>Circle One</u>	APPROVED	DENIED	Reviewer	Date
# of Treatments Approved			Start Date	Ending Date	
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Extension #2	<u>Circle One</u>	APPROVED	DENIED	Reviewer	Date
# of Treatments Approved			Start Date	Ending Date	

COMMENTS: _____

NOTE: These benefits are applicable only if the patient is eligible for the Employees Group Insurance program (HealthChoice), and are subject to ALL POLICY PROVISIONS. Please remember to verify benefits and eligibility by calling 1-800-782-5218.
MEDICARE PATIENTS: If HealthChoice is supplement, all services requested must be approved by Medicare.