



3545 NW 58<sup>th</sup>, Suite 500, Oklahoma City, OK 73112  
 Phone: 1-800-543-6044 or 1-405-717-8879  
 FAX: 1-405-717-8935

**PHYSICAL THERAPY REQUEST**

◆ This information is private and confidential.

◆ Please complete all information on this form.

Date: \_\_\_\_\_  
 Therapy Group Name: \_\_\_\_\_ Tax ID Number: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Patient: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Member (if other than patient): \_\_\_\_\_ Member ID #: \_\_\_\_\_  
 Date of Surgery: \_\_\_\_\_

Summary Progress Towards Current PT Goals: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

New PT Goals: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**TREATMENTS**

Initial Evaluation: \_\_\_\_\_ Total # Additional Treatments Requested: \_\_\_\_\_  
 2<sup>nd</sup> 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	Circle One	APPROVED	DENIED	Reviewer	Date
# of Treatments Approved			Start Date		Ending Date
Extension #2	Circle One	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.