

## Foundation Authorization Request For Continued PT & OT

Fax Completed Form to 707-442-2047 or Mail to the Foundation, P.O. Box 1395, Eureka, CA 95502

Incomplete request forms will be returned without being processed.

Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

### Foundation Authorization Tracking Number:

#### MEMBER INFORMATION

Patient Name: \_\_\_\_\_ Gender: M / F Date of Birth: \_\_\_\_\_

Patient's Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Health Plan: HMO: Anthem Blue Cross CaliforniaCare HMO/POS - Blue Shield Cal PERS HMO

PPO: Blue Lake Rancheria - Trinidad Rancheria

Member's Primary Care Provider: \_\_\_\_\_ Member ID# \_\_\_\_\_

#### REQUESTING PROVIDER INFORMATION

#### PROPOSED PROVIDER & FACILITY INFORMATION

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Tax ID # (Out of Area Providers only): \_\_\_\_\_

Request Date: \_\_\_\_\_ Place of Service: Office

### REQUEST FOR CONTINUATION OF PT & OT SERVICES – MEDICAL NECESSITY

Diagnosis: \_\_\_\_\_ ICD9(s): \_\_\_\_\_

Initial evaluation (Date) \_\_\_\_\_ Reassessment (Date) \_\_\_\_\_ Total visits to date: \_\_\_\_\_

Specific goal of continued treatment period: \_\_\_\_\_

Reason goals not met in initial treatment period: \_\_\_\_\_

Is patient able to meet ADLs without excessive pain? \_\_\_\_\_

Treatment modalities being used: \_\_\_\_\_

Barriers to patient transitioning to HEP: \_\_\_\_\_

Request: \_\_\_ Visits/Week x \_\_\_ Weeks = \_\_\_ Total Visits CPT Code(s): \_\_\_\_\_

Therapist Comments: \_\_\_\_\_

\_\_\_\_\_ Therapist Signature \_\_\_\_\_

Referring Provider Comments: \_\_\_\_\_

\_\_\_\_\_ Referring Provider Signature \_\_\_\_\_

- Approved authorizations are effective from the date they are received and expire in three (3) months. Authorizations are based on the member's current Approved authorizations are effective from the date they are received and expire three (3) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed. Providers must verify member eligibility within 5 days of the date of service to ensure coverage..
- Claims for services rendered without required prior authorization may be denied reimbursement. Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services.
- The requesting physician or the member may submit authorization appeals to the Foundation Medical Management Department.
- This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety Code §1370, and California Evidence Code §1157.

#### CONFIDENTIAL INFORMATION

This facsimile is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is strictly prohibited. If you have received this message by error, please notify us immediately and destroy the related message. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.