

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. A copy of this form should be kept in the patient's chart.
Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

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| Foundation Authorization Tracking Number: | |
| MEMBER INFORMATION | |
| Patient Name: _____ Gender: <u>M</u> / <u>F</u> Date of Birth: _____ | |
| Patient's Address: _____ Street City Zip | |
| Health Plan: CaliforniaCare(HMO/POS) - PALCO - St. Joseph Hospital/RMH - Trinidad Rancheria - Blue Lake Rancheria - Blue Shield HMO Phone: _____ | |
| Subscriber Name: _____ Group #: _____ | |
| Member's Primary Care Provider: _____ Subscriber #: _____ | |

| 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 Outpatient Hosp Inpatient Hosp |

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| REQUEST FOR CONTINUATION OF PT & OT SERVICES – MEDICAL NECESSITY | |
| Diagnosis: _____ ICD9(s): _____ | |
| Initial evaluation (Date) _____ Reassessment (Date) _____ Total visits to date: _____ | |
| Pain: Initial _____ /10 Current _____ /10 Goal _____ /10 | |
| Strength: Initial _____ Current _____ Goal _____ | |
| Flexibility: Initial _____ Current _____ Goal _____ | |
| Function: Initial _____ Current _____ Goal _____ | |
| Overall: Initial _____ Current _____ Goal _____ | |
| Barriers to patient transitioning to home/independent care, if any? _____ | |
| 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 eligibility.
- Claims for services rendered without required prior authorization may be denied reimbursement. Claims for the above services must be submitted using the same CPT code and provider group (tax id #) as those approved or include documentation to explain the medical necessity of alternative 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.