

## Foundation Authorization Request For Continued PT & OT

Fax Completed Form to 707-442-2047 or Mail to: 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.

### Foundation Authorization Tracking Number:

#### MEMBER INFORMATION

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

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

Health Plan: Anthem Blue Cross HMO/POS - Blue Shield HMO - Blue Lake Rancheria – Open Door - SJHS Humboldt - Trinidad Rancheria

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: <input type="checkbox"/> Office <input type="checkbox"/> Outpatient Hosp <input type="checkbox"/> Inpatient Hosp

### 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.

