1199SEIU Funds
Benefit and Pension

National Benefit Fund • Health Care Employees Pension Fund
Greater New York Benefit Fund • Greater New York Pension Fund
Home Care Employees Benefit Fund • Home Care Employees Pension Fund
330 WEST 42ND STREET | NEW YORK, NY 10036-6977 | WWW.1199SEIUBENEFITS.ORG

Care Management Programs
PT, OT, & ST for Authorization
Benefit Extensions beyond 25 visits/calendar year

Fax completed form with supporting clinical documentation to (646) 473-7447

Request Submitted By _____ **Request Date** _____ / _____ / _____

☐ PT ☐ OT ☐ ST

1199SEIU MEMBER INFORMATION

Member Name _____ _____
Last Name First Name

Member ID | | | | | | | | | | |

PATIENT INFORMATION (*If not the Member*)

Patient Name _____ _____
Last Name First Name

Date of Birth _____ / _____ / _____

CPT/HCPCS Code(s) & Description

Code _____

Description _____

_____

ICD 10 Code(s) & Description

PRINCIPAL _____

Description _____

_____

SECONDARY _____

Description _____

_____

Member ID | | | | | | | | | |

Patient Name _____ _____

Last Name First Name

Total # of therapy visits rendered to date for current calendar year: ☐

Additional visits requested: ☐

Reason for continuing treatment:

Is this request relating to post-surgical care? ☐ No ☐ Yes

If yes, Type of Surgery _____ Date ____ / ____ / ____

Fax initial/re-evaluation and up-to-date progress notes along with this completed form to support the following:

Functional level:

Assessment of change in patient condition since last visit:

Treatment plan:

Treatment goals:

Expected outcome:

Range of motion values: _____

Muscle Strength: **0 -1 1 1+ -2 2 +2 -3 3 3+ -4 4 +4 -5 5**

☐ **TRACE** ☐ **POOR** ☐ **FAIR** ☐ **GOOD** ☐ **NORMAL**

Member ID | | | | | | | | | |

Patient Name _____ _____

Last Name First Name

PHYSICIAN INFORMATION

Physician Name _____ **Date** _____ / _____ / _____

Physician Specialty _____ **Telephone** (____) ____ - _____

Fax (____) ____ - _____

TIN (*Tax ID*) _____

Address _____

Street Name City State Zip Code

FACILITY/VENDOR INFORMATION *(Facility/Vendor providing the service)*

Facility/Vendor Name _____

TIN *(Tax ID)* _____ **Telephone** (____) ____ - _____

Fax (____) ____ - _____

Address _____

Street Name City State Zip Code

Vendor Authorized Signature _____

Name _____ **Title** _____

Please print clearly

Contact Person _____ **Title** _____

Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST.

In order to process your request, the Provider TIN & Fax #'s along with the CPT/HCPS & ICD 10 codes must be included. Complete this form and attach copies of pertinent medical documentation or copies of the physician's actual office chart to support your request. Fax completed form to (646) 473-7447.

The Fund's Pre-Authorization Call Center is available Monday to Friday, 9:00 AM to 5:00PM at (646) 473-7446. Pre-authorization requirements are regularly updated and are therefore subject to change; periodically visit the website at www.1199SEIUBenefits.org for our most recent pre-authorization requirements, authorization request forms and other pertinent information located in the "For Providers" section.