1199SEIU Benefit Funds

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CARE MANAGEMENT DEPARTMENT
PT, OT, ST AND ACUPUNCTURE REQUEST FORM

For Benefit Extensions Beyond 25 Visits/Calendar Year

Fax completed form to (646) 473-7447. Include initial/re-evaluation report inclusive of initial and current progress notes.

MEMBER'S FULL NAME (FIRST, LAST) | MEMBER ID #

PATIENT'S FULL NAME (IF NOT MEMBER) (FIRST, LAST) | PATIENT'S DATE OF BIRTH (MM/DD/YYYY) | AGE

Relationship To Member: ☐ Self ☐ Spouse ☐ Child

REQUEST SUBMITTED BY | DATE (MM/DD/YYYY)

PHYSICIAN'S FULL NAME | DATE (MM/DD/YYYY)

PHYSICIAN'S SPECIALTY | TAX ID # (TIN)

TELEPHONE | MD FAX #

OFFICE ADDRESS | CITY | STATE | ZIP CODE

NAME OF FACILITY/VENDOR PROVIDING SERVICE

TAX ID # (TIN) | FACILITY/VENDOR FAX #

ADDRESS | CITY | STATE | ZIP CODE

X _____

VENDOR AUTHORIZED SIGNATURE | DATE (MM/DD/YYYY)

PRINT FULL NAME | TITLE

CONTACT PERSON | TITLE

TELEPHONE

Service type: ☐ PT ☐ OT ☐ ST ☐ Acupuncture

Total number of therapy visits rendered to date for current calendar year: _____ Additional visits requested: _____

Is patient's condition related to:

Employment? ☐ Yes ☐ No

Auto accident? ☐ Yes ☐ No If yes, date: _____ DATE (MM/DD/YYYY)

Other accident? ☐ Yes ☐ No If yes, date and type of accident: _____ DATE (MM/DD/YYYY) TYPE OF ACCIDENT

Is legal action being taken? ☐ Yes ☐ No

Is there other insurance? ☐ Yes ☐ No If yes, list: _____

_____

Reason for continuing treatment: _____

Is this request relating to post-surgical care? ☐ Yes ☐ No If yes, date and type of surgery:

_____

DATE (MM/DD/YYYY) TYPE OF SURGERY

ICD-10 Code(s) and Description:

Principal: _____

Secondary: _____

CPT Codes: _____

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

Range of motion values:					
Muscle Strength:	0 -1 1 1+	-2 2 +2	-3 3 3+	-4 +4	-5 5
	☐ Trace	☐ Poor	☐ Fair	☐ Good	☐ Normal

_____

FUNCTIONAL LEVEL

_____

_____

ASSESSMENT OF CHANGE IN PATIENT CONDITION SINCE LAST VISIT

_____

_____

TREATMENT PLAN

_____

_____

LIST QUANTIFIABLE AND ATTAINABLE TREATMENT GOALS

_____

_____

EXPECTED OUTCOME

_____

Please note: In order to process your request, the Provider TIN and Fax #'s along with the CPT/HCPCS and 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. The Funds' Pre-authorization Call Center is available Monday to Friday, 9:00 am to 5:00 pm, at (646) 473-7446. Pre-authorization requirements are regularly updated and are therefore subject to change; periodically visit the website at www.1199SEIUFunds.org for our most recent pre-authorization requirements, authorization request forms and other pertinent information located in the "For Providers" section.