Outpatient Therapy Precertification Request Form

Date of Request: _____ **Requested Service(s):** ☐ PT ☐ OT ☐ ST	**PHP Utilization Management** **Phone 720.612.6600 l Fax 303.605.1545**

Member Info:

Last Name: _____ Insurance ID #: _____

First Name: _____ DOB: _____

Requesting Outpatient Therapy Provider Info:

Outpatient Therapy Agency Name: Phone: _____

_____

Office Contact: _____ Fax: _____

Physician Following Plan of Care:

Provider Name: _____ Phone: _____

Office Contact: _____

Outpatient Therapy Authorization Request & Supporting Documentation Requirements:

☐ **Initial Review Period AFTER Start of Care (SOC):**

1. Physician signed or verbal order or Plan of Care (within 14 days of starting service)
2. State number of visits/units and length of time planned
3. Start of care date

☐ **Extension of Services:**

1. Submit a new request for prior authorization for extension of the care plan
2. Physician signed or verbal orders
3. Progress notes showing progress, goals, etc.

☐ **ADDITIONAL CLINICAL ONLY for Authorization Request # _____**

Electronic signature or verbal order acceptable for signatures when physician name is clearly identified & included in the requested documentation

ICD-10 / Diagnosis Code	**1.**	**2.**	**3.**	**4.**
CPT Code including # of Visits per Code	**1.**	**2.**	**3.**	**4.**

Comments: _____

_____

****IMPORTANT****

To ensure a timely determination on your request, please include all the identified supporting documents with the request to PHP PA Department at 303.605.1545 (fax). This will help facilitate processing and eliminate need for unnecessary phone calls.

Authorization is not a guarantee of payment. Coverage will be determined based on eligibility and availability of remaining benefits at the time of service.