Authorization Form
Outpatient Therapy/Cardiac or Pulmonary Rehab Request

Phone: 1-800-521-6622 | Fax: 1-866-755-9949

Contact name:

Phone number: Fax number:

Member information	
Member name:	Member ID number:
Date of birth:	Member's phone number:
Authorization number, if applicable:	
Primary insurance? ☐ Yes ☐ No	Name of carrier:
Primary insurer member ID:	Primary authorization number:

Provider information	
Ordering physician name:	Physician Tax ID/NPI:
Physician phone number:	Physician fax number:
Facility name:	Facility Tax ID/NPI:
Facility phone number:	Facility fax number:

Codes

ICD diagnosis code	CPT code	Start date	Frequency (number of times per week)	Duration (number of weeks)

Therapy/rehab information

Provide date member completed their 24th therapy visit for the current calendar year:

Additional information:

CLINICAL NOTES TO SUPPORT THE MEDICAL NEED OF THIS SERVICE ARE REQUIRED.

ALL FIELDS MUST BE COMPLETED FOR REQUEST TO BE PROCESSED.