PART B OUTPATIENT THERAPY REQUEST FORM

Submit this completed form by fax to **1-833-610-2399** or on our provider portal:
https://secure.healthx.com/PerennialAdvantage.Provider
Call 1-844-788-6959 (TTY 711) for CO/PA or 1-844-788-6986 (TTY 711) for OH to speak with a representative.

Members must be referred to in-network facilities and providers unless emergent, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

☐ Routine/Standard ☐ Serious jeopardy to the member's life or health or ability to regain maximum function

MEMBER INFORMATION			
Member Name:		Member ID:	
Date of Birth:	Member Residence:		
REQUESTING PROVIDER/FACILITY			
Requestor's Name (Print):	Phone Number:	Fax Number:	Date of Request:
Referring Provider (If other than requestor):	Referring Provider: ☐NP/PA ☐PCP ☐Therapy Rep ☐Other		
SERVICING PROVIDER/FACILITY			
Admitting/ Servicing Facility/ Provider Name:			
NPI/ TIN Number:	Phone Number:	Fax number:	
SERVICE TYPE REQUESTED			
☐Initial Request ☐ Extension Request, Previous Auth #			

Therapy/Home Health:				
☐Outpatient Therapy ☐Home Health Significant Improvement made? ☐Yes ☐No Significant change in health status? ☐Yes ☐No Maintenance Therapy? ☐Yes ☐No	Type:	Visits/Week:	Number of Weeks:	Total quantity (multiply previous columns):
	☐PT			
	☐OT			
	☐ST			
	☐SN (HH only)			
Date of Service/Start of Care:				
Current Primary Diagnoses and ICD-10 Code(s):				
Additional Request Details:				

CLINICAL INFORMATION
• Clinical/ therapy documentation/ assessments should be within 72 hours of request. • Documents to attach (applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, etc.
OUT-OF NETWORK SERVICES ONLY
• Has the service been scheduled already? ☐Yes ☐No • Is this a specialized service that no other In-network provider can render? ☐Yes ☐No • Does the member have an established relationship with the provider that should not be interrupted? ☐Yes ☐No If "Yes", explain (include last visit date):