



# PATIENT INTAKE FORM

Fax this request to 1-855-825-7820. This form must be filled out in its entirety. For inquiries or status of pending requests, call: 1-855-825-7818 or visit the Provider Web Portal

- Routine
- Urgent (An expedited/urgent request is only warranted when applying the standard timeframe for making a determination could seriously jeopardize the enrollee's health, life, or ability to regain maximum function)

**PLEASE SUBMIT ONE FORM PER DISCIPLINE**

Member ID Number		Member Health Plan	Member County
Member Last Name		Member First Name	Member Telephone Number
Member Date of Birth (mm/dd/yyyy)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Request Date (mm/dd/yyyy)
Referring Provider Name	Phone Number	Fax Number	Referring Provider NPI
Facility/Group Name (Rendering Provider)			Facility/Group TIN Number
Facility/Group Address			Facility/Group NPI
City			State <span style="margin-left: 20px;">Zip Code</span>
Contact Person Name	Facility Phone Number		Facility Fax Number (Required for Fax Notifications)
Treating Therapist Last Name	Treating Therapist First Name		Treating Therapist NPI
Line of Business: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid Healthy Kids	Place of Service: <input type="checkbox"/> Office (11) <input type="checkbox"/> Member Home (12) <input type="checkbox"/> Outpatient Hosp (22) <input type="checkbox"/> Independent Clinic (49) <input type="checkbox"/> Other [ ___ ]		

Primary Diagnosis Description:

ICD Code(s)	CPT Code(s)
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If Status Post Surgery, List Procedure

Date of Surgery (mm/dd/yyyy)	For Cerebral Vascular Accident (CVA), list Date of CVA (mm/dd/yyyy)
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<input type="checkbox"/> Please check box to confirm Member's Plan of Care has been submitted and approved by ordering Provider and the frequency and duration are: _____ times/ per week _____ number of weeks	<input type="checkbox"/> Please check box to confirm The servicing provider has reviewed the approved Plan of Care with the Enrollee, including the frequency and duration, and will provide these services.	<input type="checkbox"/> Please check box to confirm Ordering Provider will be notified when therapy has been completed and whether the goals have been achieved (Member discharged) or Therapy was stopped.
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**FILL OUT SEPARATE PATIENT INTAKE FORM FOR EACH DISCIPLINE**

<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy	Evaluation Date (mm/dd/yyyy):	Test Used (Attach Test Scores)
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Note/Comments

For school aged children, submit IEP, or reason for non-availability of IEP

I, the undersigned, hereby attest that the information provided above is accurate and truthful to the best of my knowledge and belief.

Provider or Authorized Representative Signature	Print Name	Date
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