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Habilitative Therapy Request Form for HMO Members

for Physical and Occupational Therapies

Please attach initial evaluation and most recent progress summary, including short and long term goals, and fax to:
BCBSMA Clinical Coordination department at **1-866-577-9901**

- **For BCBSMA employees: 1-617-246-4299**

Use this form ONLY for habilitative services.

Reminder: Some members have a **combined** rehabilitation and habilitation benefit; some members have separate visit limits. Use our provider technology to check your patients' eligibility and benefits before rendering service.

Requested Services:

Requested Habilitative Services: ❑ Physical Therapy ❑ Occupational Therapy

Type of request: ❑ Initial ❑ Ongoing

Extension start date: / / Anticipated discharge date: / /

# of visits requested in this 8-week period: _____

Patient Information:

Member name: _____

Date of birth: / /

Member ID: _____

Referral/Authorization #: _____

ICD-10 Code: _____

Date of onset/exacerbation: / /

Initial evaluation date for current diagnosis: / /

Provider Information:

Provider name: _____

NPI: _____

Therapist name: _____

Telephone: ( )

Fax: ( )

Contact name: _____

Referring MD: _____

NPI: _____

MD telephone #: ( )

Please attach required clinical outlined below:

	Current valid physician prescription for services
	Initial Evaluation
	Monthly progress notes
	Updated treatment plan signed by physician
	Any additional pertinent information not otherwise included above

Attestation

- Our practice has a current prescription to provide physical or occupational therapy services.
- Our practice has confirmed that the ordering physician is the primary care provider or a specialist with an active referral or authorization.

_____

Signature Printed name Date