Print Clear form

MASSACHUSETTS

HABILITATIVE THERAPY REQUEST 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:

- **Health & Medical Management** at **1-866-577-9901**
- **For Blue Cross employees,** fax to **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:

	Annual evaluation
	Two most recent progress notes
	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