



SHORT-TERM REHABILITATION THERAPY EXTENSION REQUEST FORM

For Physical and Occupational Therapies

Please attach initial evaluation and most recent progress summary and fax to Health & Medical Management at **1-866-577-9901**, or:

For Blue Cross employees, please fax to: **1-617-246-4299**

For Medicare Advantage members, please fax to: **1-800-447-2994**

[Additional instructions for completing this form](#)

MEMBER INFORMATION		PROVIDER INFORMATION	
Member name:		Provider name:	
Date of birth:		NPI:	
Member ID:		Therapist name:	
Referral/authorization #:		Phone #:	
Diagnosis:		Fax #:	
Date of onset/exacerbation:		Contact name:	
Initial evaluation date for current diagnosis:		Referring MD:	
Is this work-related?	<input type="checkbox"/> Yes <input type="checkbox"/> No	MD Phone #:	
Is this the result of a motor vehicle accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous treatment for this diagnosis:			
Treatment for other diagnoses (within the previous year):			

REQUESTED SERVICES			
Requested services:	<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Occupational therapy	
Extension start date:		Anticipated discharge date:	
# of visits requested in this 4-week period:			
Is the member receiving speech therapy elsewhere? <i>(check all applicable)</i>	<input type="checkbox"/> School	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Other:

CLINICAL UPDATE ON PROGRESS TOWARD GOALS:				
Problem list	Initial evaluation (1st extension only):	Previous status:	Current status:	Goals:
Pain				
Range of motion (ROM)				
Strength				
Function (include functional update, ADL/IADL findings, limitations)				
Barriers to progress:				
Treatment plan for this diagnosis:				