

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/AlignSeniorCare.Provider>

Call California: 1-844-305-3879 (TTY 711), Florida: 1-844-788-8935 (TTY 711), Michigan: 1-855-855-0336 (TTY 711) 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:			
	<input type="checkbox"/> NP/PA <input type="checkbox"/> PCP <input type="checkbox"/> Therapy Rep <input type="checkbox"/> Other			
SERVICING PROVIDER/FACILITY				
Admitting/ Servicing Facility/ Provider Name:				
NPI/ TIN Number:	Phone Number:	Fax number:		
SERVICE TYPE REQUESTED				
<input type="checkbox"/> Initial Request <input type="checkbox"/> Extension Request, Previous Auth #				
Therapy/Home Health:				
<input type="checkbox"/> Outpatient Therapy <input type="checkbox"/> Home Health Significant Improvement made? <input type="checkbox"/> Yes <input type="checkbox"/> No Significant change in health status? <input type="checkbox"/> Yes <input type="checkbox"/> No Maintenance Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Visits/Week:	Number of Weeks:	Total quantity (multiply previous columns):
	<input type="checkbox"/> PT			
	<input type="checkbox"/> OT			
	<input type="checkbox"/> ST			
	<input type="checkbox"/> SN (HH only)			
Date of Service/Start of Care:				
Current Primary Diagnoses and ICD-10 Code(s):				
Additional Request Details:				

CLINICAL INFORMATION
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Has the service been scheduled already? <input type="checkbox"/>Yes <input type="checkbox"/>No • Is this a specialized service that no other In-network provider can render? <input type="checkbox"/>Yes <input type="checkbox"/>No • Does the member have an established relationship with the provider that should not be interrupted? <input type="checkbox"/>Yes <input type="checkbox"/>No If "Yes", explain (include last visit date):