



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: ☐ NP/PA ☐ PCP ☐ Therapy Rep ☐ Other		

SERVICING PROVIDER/FACILITY

Admitting/ Servicing Facility/ Provider Name:		
NPI/ TIN Number:	Phone Number:	Fax number:

SERVICE TYPE REQUESTED

☐ Initial Request ☐ Extension Request, Previous Auth #

Therapy/Home Health:

☐ Outpatient Therapy ☐ Home Health	Type:	Visits/Week:	Number of Weeks:	Total quantity (multiply previous columns):
Significant Improvement made? ☐ Yes ☐ No Significant change in health status? ☐ Yes ☐ No Maintenance Therapy? ☐ Yes ☐ No	☐ PT			
	☐ OT			
	☐ ST			
	☐ SN (HH only)			
Date of Service/Start of Care:				
Current Primary Diagnoses and ICD-10 Code(s):				
Additional Request Details:				

CLINICAL INFORMATION
• 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
• Has the service been scheduled already? ☐Yes ☐No • Is this a specialized service that no other In-network provider can render? ☐Yes ☐No • Does the member have an established relationship with the provider that should not be interrupted? ☐Yes ☐No If "Yes", explain (include last visit date):