



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/NHCAdvantage.Provider>

Call 1-844-854-6886 (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

☐ Initial Request ☐ Extension Request, Previous Auth #

Therapy/Home Health:

<input type="checkbox"/> Outpatient Therapy <input type="checkbox"/> Home Health	Type:	Visits/Week:	Number of Weeks:	Total quantity (multiply previous columns):
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	<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):