

<b>Request Priority: Care must be rendered:</b>		<input type="checkbox"/> within 72 hours	<input type="checkbox"/> outside 72 hours
<b>Service Type:</b>		<b>Requesting Provider Information</b>	
<input type="checkbox"/> Specialty Referral/Global Maternity		Requesting Provider Telephone Number: ( ) -	
Q1	<input type="checkbox"/> Physical or Occupational Therapy	Requesting Provider Fax Number: ( ) -	
	<input type="checkbox"/> OP Behavioral Health	Contact Name: _____	
Q2	<input type="checkbox"/> OP Medical Care/Procedure	Requesting Provider/Facility Name: _____	
	<input type="checkbox"/> DME/Radiology	Physician State License #: _____	
	<input type="checkbox"/> Speech Therapy	Requesting Provider NPI #: _____	
Q3	<input type="checkbox"/> Outpatient Surgery	Billing Tax ID #: _____	
	<input type="checkbox"/> IV Therapy/Home Health	Correspondence Preference: <input type="checkbox"/> Fax <input type="checkbox"/> US Mail	
	<input type="checkbox"/> Adjunctive Dental	Is the Requesting Provider Performing the Service? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Hospice/Respite Care	Is this a continuation/ extension of services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IP	<input type="checkbox"/> Inpatient Physical Health	Anticipated Date of Service: ____ / ____ / ____	
IBH	<input type="checkbox"/> Inpatient Behavioral Health		
	<input type="checkbox"/> PHP		
<b>Patient Information (Please complete all fields)</b>			
Sponsor SSN: _____ - _____ - _____			
Patient Name (Last, First, MI): _____		Patient Date of Birth: ____ / ____ / ____	
Patient Address: _____ ZIP Code _____			
Street _____		City _____ State _____	
Patient Home Phone: ( ) - _____		Other Health Insurance: _____	
<b>Servicing Provider Information (Complete all applicable fields)</b>			
<b>Specialty:</b> _____			
Servicing Provider Name: _____		Phone: ( ) - _____	
Address: _____		Fax: ( ) - _____	
<b>Facility Name (If Applicable):</b> _____		Phone: ( ) - _____	
Address: _____		Fax: ( ) - _____	
<b>Requested Service Information (Complete as many sections as required)</b>			
Diagnosis: Code: _____		Description: _____	
Code: _____		Description: _____	
Service 1: CPT/HCPC/NDC Code: _____		Description: _____	
Number of Visits: _____		Frequency: _____	
Duration: _____		If DME: <input type="checkbox"/> Purchase <input type="checkbox"/> Rental	
If Global Maternity – Due date ____ / ____ / ____			
Service 2: CPT/HCPC/NDC Code: _____		Description: _____	
Number of Visits: _____		Frequency: _____	
Duration: _____		If DME: <input type="checkbox"/> Purchase <input type="checkbox"/> Rental	
Service 3: CPT/HCPC/NDC Code: _____		Description: _____	
Number of Visits: _____		Frequency: _____	
Duration: _____		IF DME: <input type="checkbox"/> Purchase <input type="checkbox"/> Rental	
<b>Attach Clinical History/previous treatment/plan of treatment, supporting lab/X-ray reports, etc., if necessary.</b>			