PASSPORT ADVANTAGE (HMO SNP)

Therapy Prior Authorization Request Form

Complete this entire treatment plan to avoid delays in processing your request
Fax completed request to: **888-367-7480**

☐ Routine Request ☐ Urgent Request

URGENT / EXPEDITED is defined as: if waiting under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. For Urgent / Expedited requests you may call: **844-865-7864**

Today's date ___________ Member Name ______________________________ Member ID ______________
Member DOB ________________________________ Ordering MD ______________________________
Requesting Provider: ____
NPI: __________________________________ Provider Contact: ____________________________________
Telephone: ________________________________ Fax: ____

Therapy type requested: ☐ PT ☐ OT ☐ Speech (Select all that apply)
# of visits requested: __________________________ Frequency of visits: ____________________________
Start DOS: __________________________________ End DOS: _____________________________________

Therapy start date:

Therapy Type	ORIGINAL Start Date	Times per Week

What is being requested?

Therapy Type	Date Range		Times per Week
	TO	FROM	

Date of onset of symptoms _______________________ Accident or work-related? ☐ YES ☐ NO
If yes, provide TPL (Third Party) information ____

Date of Evaluation ________________________ Re-evaluation __________________________

PHYSICAL EXAM FINDINGS: include objective functional assessment, neurological deficits noted, degree of disability, responses to previous treatment, and progression of condition

RADIOLOGIC STUDIES: include dates and results

FUNCTIONAL/PHYSICAL DISABILITY: include extent of change using scale provided

Symptoms: 0 = no pain to10 = extreme pain

- ☐ Pain – location ____________________
- ☐ Headache – describe ______________
- ☐ Other – specify ___________________

Level of impairment: 0 = no impairment to 3 = severe impairment

- ☐ Driving ___________
- ☐ Sleep _____________
- ☐ Recreation _________
- ☐ Personal Care _______________
- ☐ Working ____________________
- ☐ Difficulty Lifting ______________

CURRENT MEDICATIONS FOR ABOVE DIAGNOSIS:

NSAID's

Name of Drug	Dosage	Date Started

Opiates

Name of Drug	Dosage	Date Started

PREVIOUS INTERVENTIONS:

Physical Therapy:

How many visits _____________ When ________________ Where _____________ Relief? ☐ YES ☐ NO

CURRENT STATUS:

TREATMENT PLAN:

SHORT TERM GOALS:

LONG TERM GOALS:

Therapist Signature: ____ Date: ___________________