



Care Management Programs Department
PT, OT & ST\* Request Form
For Benefit Extensions beyond 25 visits/calendar year

Fax completed form to (646) 473-7447. Include Initial/Re-evaluation report inclusive of initial and current progress notes.



1199SEIU Member's Name: \_\_\_\_\_

Member ID [grid of 10 boxes]

Patient (if not member): \_\_\_\_\_ Patient date of birth: \_\_\_\_\_ Age: \_\_\_\_\_



Request submitted by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician Specialty: \_\_\_\_\_ Telephone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

TIN # (Tax ID): \_\_\_\_\_ MD Fax #: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Office Address: \_\_\_\_\_

Name of Facility/Vendor Providing Service: \_\_\_\_\_

TIN # (Tax ID #): \_\_\_\_\_ Vendor Fax Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_

Vendor Authorized Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Telephone: (\_\_\_\_)\_\_\_\_-\_\_\_\_



Service Type: [ ] PT [ ] OT [ ] ST

Total # of therapy visits rendered to date for current calendar year: \_\_\_\_\_ Additional visits requested: \_\_\_\_\_

Is Patient's Condition Related To:

- Employment? (Current or Previous) [ ] No [ ] Yes
Auto Accident? [ ] No [ ] Yes if yes, date \_\_\_\_\_
Other Accident? [ ] No [ ] Yes if yes, date & type of accident \_\_\_\_\_

Is legal action being taken? [ ] No [ ] Yes

Is There Other Insurance? [ ] No [ ] Yes If yes, List \_\_\_\_\_

