



Therapy Referral Request
Cardiac, Pulmonary, Physical, Occupational and Speech Therapy

To Request a referral for an PSHP member, complete this form and fax to 1-866-532-8834

- New Request
Treatment in progress

Provider Information

Provider/Facility Name: Date of Service:
Provider Fax: Work Phone:
Contact Person: Telephone:
Provider ID: Therapist:

Patient Information

Patient Name: Last First Middle DOB:
Medicaid Number: Diagnoses:
Surgical Procedures and dates:
Date of initial therapy evaluation: Total number of Patient visit:

Plan of Care

- Attachments: Medical Records or additional information

Problem List (Clinical and Functional) Associated Goals (Objective and Measurable)
1. 1.
2. 2.
3. 3.

Requested Frequency and Duration X per week for weeks
Total Visits: Number of units:

Authorization

** All services are subject to eligibility at the time of Service**An authorization is not a guarantee of payment**

- Approved as requested
Approved frequency/duration X per week for weeks Total Visits:
Number of units:
Pending: Please send Initial Evaluation Progress notes starting

Comments:

Nurse: Date:
Authorization #: Start Date: End Date:
Date fax to provider: