



Therapy Information Request Form

To: UMR	From:
Fax:	Fax:
Case#	Phone:
	Pages (including cover):
Comments:	
<p>Please see the information form below. This information is required in order to review the requested procedure against the medical policy. The information will assist us in providing a timely determination of coverage for your patient's request.</p> <p>An accurate decision cannot be made without this information.</p> <p>Thank You,</p> <p>United HealthCare policies can be viewed in detail at: www.unitedhealthcareonline.com under Policies and Protocols then Medical and Drug Policies.</p>	

CONFIDENTIALITY NOTICE: Information accompanying this facsimile is considered to be UnitedHealthcare's confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed. Such recipient shall be liable for using and protecting UnitedHealthcare's information from further disclosure or misuse, consistent with applicable contract and/or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties. If you believe you received this information in error, please contact the sender immediately.

Patient's Full Name:	Date of Birth:
Member ID:	Case Reference Number:

- **Please include:**
 - **Current and relevant patient history (signs/symptoms)**
 - **Goals (Current progress report if ongoing therapy)**
 - **MD order**

- **Indicate below:**
 - **The therapy and code/s being requested (PT, OT, ST)**
 - **Start date of current request (for additional visits-please put the new/concurrent start date, not the date of initial request)**
 - **Number of visits being requested**
 - **Number of visits previously used**
 - **Name of ordering MD**

- **Please complete and fax the completed form with clinical documentation**

Therapy Requested: _____

Start Date of Current Request: _____

Number of Visits Being Requested: _____

Number of Visits Previously Used: _____

Therapy Requested: _____

Start Date of Current Request: _____

Number of Visits Being Requested: _____

Number of Visits Previously Used: _____

****Name of Ordering MD/ Address/Phone Number:** _____

Facility Name/Address/Phone Number: _____