Therapy Information Request Form

To: UMR	From:
Fax:	Fax:
Case#	Phone:
	Pages (including cover):
Comments:	

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.

An accurate decision cannot be made without this information.

Thank You,

United HealthCare policies can be viewed in detail at: www.unitedhealthcareonline.com under Policies and Protocols then Medical and Drug Policies.

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:_____