



## PART B OUTPATIENT THERAPY REQUEST FORM

Submit this completed form by fax to **1-833-610-2399** or on our provider portal:  
<https://secure.healthx.com/KeyCareAdvantage.Provider>  
 Call 1-844-206-1205 (TTY 711) to speak with a representative.

Members must be referred to in-network facilities and providers unless emergent, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

- Routine/Standard
  Serious jeopardy to the member's life or health or ability to regain maximum function

**MEMBER INFORMATION**

|              |            |
|--------------|------------|
| Member Name: | Member ID: |
|--------------|------------|

|                |                   |
|----------------|-------------------|
| Date of Birth: | Member Residence: |
|----------------|-------------------|

**REQUESTING PROVIDER/FACILITY**

|                           |               |             |                  |
|---------------------------|---------------|-------------|------------------|
| Requestor's Name (Print): | Phone Number: | Fax Number: | Date of Request: |
|---------------------------|---------------|-------------|------------------|

|   |  |
|---|--|
| Referring Provider (If other than requestor): | Referring Provider:<br><input type="checkbox"/> NP/PA <input type="checkbox"/> PCP <input type="checkbox"/> Therapy Rep <input type="checkbox"/> Other |
|---|--|

**SERVICING PROVIDER/FACILITY**

|   |
|---|
| Admitting/ Servicing Facility/ Provider Name: |
|---|

|                  |               |             |
|------------------|---------------|-------------|
| NPI/ TIN Number: | Phone Number: | Fax number: |
|------------------|---------------|-------------|

**SERVICE TYPE REQUESTED**

Initial Request
  Extension Request, Previous Auth #

**Therapy/Home Health:**

|  |       |              |                  |   |
|--|-------|--------------|------------------|---|
| <input type="checkbox"/> Outpatient Therapy<br><input type="checkbox"/> Home Health  | Type: | Visits/Week: | Number of Weeks: | Total quantity (multiply previous columns): |
| <input type="checkbox"/> PT<br><input type="checkbox"/> OT<br><input type="checkbox"/> ST<br><input type="checkbox"/> SN (HH only) |       |              |                  |   |
| Significant Improvement made?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |       |              |                  |   |
| Significant change in health status?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                   |       |              |                  |   |
| Maintenance Therapy?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |       |              |                  |   |

|                                |
|--------------------------------|
| Date of Service/Start of Care: |
|--------------------------------|

|   |
|---|
| Current Primary Diagnoses and ICD-10 Code(s): |
|---|

**Additional Request Details:**



**CLINICAL INFORMATION**

- Clinical/ therapy documentation/ assessments should be within 72 hours of request.
- Documents to attach (applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, etc.

**OUT-OF NETWORK SERVICES ONLY**

- Has the service been scheduled already? Yes No
- Is this a specialized service that no other In-network provider can render? Yes No
- Does the member have an established relationship with the provider that should not be interrupted? Yes No  
If "Yes", explain (include last visit date):