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Request for Authorization
Therapy services
FAX: 1-866-946-2052

Member information

Member's name: Last:	First:	MI:	DOB:

MissouriCare ID#:	Medicaid ID#:	Member's phone #:

Requesting Provider Information

Requesting Provider Name:	Requesting Provider ID#:	Contact Name:

NPI/TIN #:	Requesting Provider Address:

Requesting Provider Fax #:	Requesting Provider Phone #:

Treating Provider Information

Treating Provider Name:	Treating Provider ID#:	Contact Name:

NPI/TIN #:	Treating Provider Address:

Treating Provider Fax #:	Treating Provider Phone #:

Facility

Facility Name:	Facility ID#:	Contact Name:

NPI/TIN #:	Facility Address:

Facility Fax #:	Facility Phone #:

Requested Services

Place of Service: □ Office □ CORF □ Home □ Hospice □ Outpatient Hospital □ Other

Indicate in the table below the CPT code(s) associated with the visit(s) or services(s) being requested, number requested, number of visits and the number of weeks requested, up to a maximum of 12 weeks. Missouri Care does not generally authorize therapy services beyond a 12-week time frame due to date-specific eligibility and to promote timely outcome reporting,

Requested Dates of Service: From: To:	Diagnosis code(s):

Therapy CPT code(s)	Visits per week	Number of weeks requested	Total visits requested

Completion of all required fields and submission of all required clinical documentation will allow the prior authorization staff to initiate medical necessity review.

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Required information and documentation (please answer completely)		
Member is under the age of 21 years at the time of this request	☐ yes	☐ no
Condition being treated is related to MVA or work injury	☐ yes	☐ no
Member age falls between birth and 3 years **AND** has 50% or greater delay in development or a diagnosed medical condition known to cause developmental delay	☐ yes	☐ no
Member has an Individualized Family Service Plan (IFSP) or Individualized Educational Program (IEP)	☐ yes	☐ no
Member has a medical condition related to injury; or services are being requested to support postoperative recovery.	☐ yes	☐ no
Member has a medical condition for which therapy services are being requested instead of surgery or prior to further diagnostic testing (e.g. ,MRI of lumbar spine)	☐ yes	☐ no
Physician determined diagnosis: ICD–10 codes:		

Required documentation:

☐ A copy of the primary care provider's current order for initiating or continuing therapy (order date must be within 14 days of request date).

☐ Initial evaluation AND most recent re-evaluation (if performed prior to this request).

☐ Current Treatment Plan, which must include, at a minimum, the following to be considered complete:

- Reason for request, i.e., identify deficits, delays, or injury and impact on ADLs
- Identify established goals based on the ability of the member to (1) achieve age appropriate growth and development; (2) minimize the progression of a disability; or (3) attain, maintain, or regain functional capacity.
- Discuss treatment or activities to be performed.
- Results or outcome based on goals established, using standardized, objective, quantifiable measures.

☐ Copy of current IEP/IFSP must be provided if above indicates "yes". Please note: if services are provided through an IEP, they are billed through MO HealthNet. For services requested outside of an IEP, please provide rationale for additional services.

☐ A copy of a written parental consent for the school to release IEP records or for the regional office, or the BSHCN service coordinator to release IFSP records, if not previously submitted for the current school year.

Comments: