DATE

Provider Name
Address Line 1
Address Line 2

RE: Participants Name and DCN

Dear Provider:

A Prior Authorization (PA) is required in order to [continue/begin] coverage of services/supplies for the above named participant. Please complete and return this form along with a letter of medical necessity from the ordering physician. You will receive notification of the PA approval or denial. Dates of service occurring before the begin date of the PA will not be considered for reimbursement. If you have any questions, please contact me.

Sincerely,

SC Name
SC Phone
SC Fax

THERAPY: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Other ___________

CPT/HCPCS Code: _________________________________________________________________

Length of Need: _________________________________ (Example: 12 weeks, 3 months, 1 year)

Sessions per Week: ______________________

Minutes per Session: ________________ (15 minutes = 1 unit of service)

Representative Signature: ___________________________ Date: ______________

DME/Supply/Item Requested: _______________________________________________________

CPT/HCPCS Code: _________________________________________________________________

Length of Need: _________________________________ (Example 3 months, 6 months, 1 year, lifetime)

Quantity Requested per Month: ________________________________

Usual and Customary Rate (UCR) per unit: __________________________________________

Representative Signature: __________________________ Date: _____________

05/31/17