Outpatient Request Form

Fax to: 1-888-299-4181

Request Priority: **Care must be rendered:** ☐ **within 72 hours** ☐ **outside 72 hours**

Service Type

	☐ Specialty Referral/Global Maternity
Q1	☐ Physical or Occupational Therapy ☐ OP Behavioral Health
Q2	☐ OP Medical Care/Procedure ☐ DME/Radiology ☐ Speech Therapy
Q3	☐ Outpatient Surgery ☐ IV Therapy/Home Health ☐ Adjunctive Dental ☐ Hospice/Respite Care
IP	☐ Inpatient Physical Health
IBH	☐ Inpatient Behavioral Health ☐ PHP

Requesting Provider Information

Requesting Provider **Telephone** Number: ( ) -

Requesting Provider **Fax** Number: ( ) -

Contact Name:

Requesting Provider/Facility Name:

Physician State License #:

Requesting Provider NPI #:

Billing Tax ID #:

Correspondence Preference: ☐ Fax ☐ US Mail

Is the Requesting Provider Performing the Service? ☐ Yes ☐ No

Is this a continuation/ extension of services? ☐ Yes ☐ No

Anticipated Date of Service: / /

Patient Information (Please complete all fields)

Sponsor SSN: - -

Patient Name (Last, First, MI): **Patient** Date of Birth: / /

Patient Address: ZIP Code

Street City State

Patient Home Phone: ( ) - Other Health Insurance:

Servicing Provider Information (Complete all applicable fields)

Specialty:

Servicing Provider Name: Phone: ( ) -

Address: Fax: ( ) -

Facility Name (If Applicable): Phone: ( ) -

Address: Fax: ( ) -

Requested Service Information (Complete as many sections as required)

Diagnosis: Code: Description:

Code: Description:

Service 1: CPT/HCPC/NDC Code: Description:

Number of Visits: Frequency: Duration:

If DME: ☐ Purchase ☐ Rental If Global Maternity – Due date / /

Service 2: CPT/HCPC/NDC Code: Description:

Number of Visits: Frequency: Duration:

If DME: ☐ Purchase ☐ Rental

Service 3: CPT/HCPC/NDC Code: Description:

Number of Visits: Frequency: Duration:

IF DME: ☐ Purchase ☐ Rental

Attach Clinical History/previous treatment/plan of treatment, supporting lab/X-ray reports, etc., if necessary.