# Request for Initial Outpatient Therapy (Form TP-1)

## Request For Initial Outpatient Therapy (Form TP-1)

| CCP - Texas Medicaid & Healthcare Partnership<br>PO Box 200735<br>Austin TX 78720-0735<br>1-800-846-7470<br>CCP FAX: 1-512-514-4212 | Texas Medicaid & Healthcare Partnership<br>CSHCN<br>PO Box 200855<br>Austin TX 78720-0855<br>1-800-568-2413 or 1-512-514-3000<br>FAX: 1-512-514-4222 |
|---|---|

| | | | |
|---|---|---|---|
| Medicaid Number: | | CSHCN Number: | |
| Client Name: | Date of birth: / / | Telephone: | |
| Client Address: | | | |
| Has the child received therapy in the last year from the public school system? ☐ Yes ☐ No | | | |
| Date of Initial Evaluation | PT | OT | SLP |

**A copy of the initial evaluation must be attached**

| | |
|---|---|
| ICD-9 Code/Diagnosis: | Date of onset: |

**Category of Therapy Being Requested**

| | | | | |
|---|---|---|---|---|
| **PT/OT for:** | ☐ Developmental anomalies | ☐ Pre-surgery | ☐ Post-surgery Date of surgery / / | |
| ☐ Cast Removal Date Removed / / | | ☐ Serial Casting | ☐ Acute Episode of Chronic Condition | |
| ☐ New Condition | ☐ Specialty Clinic | ☐ Home Program | ☐ ADL (activities of daily living) | |
| ☐ Equipment Assessment | | ☐ Equipment Training | | |
| **Speech for:** | ☐ Craniofacial | ☐ Developmental Anomalies | ☐ New Condition | ☐ Post Cochlear Implant |

**Check the service requested, indicate the date(s) of service and frequency per week or month:**
Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.

| Service Type | Service Date(s) | | Frequency per week | Frequency per month |
|---|---|---|---|---|
| | From: | To: | | |
| ☐ **PT** | / / | / / | | |
| ☐ **OT** | / / | / / | | |
| ☐ **SLP** | / / | / / | | |

Procedure code(s) for therapy services:

| Specialist | Name | Signature | Date Signed |
|---|---|---|---|
| Physician | | | / / |
| PT Therapist | | | / / |
| OT Therapist | | | / / |
| SLP Therapist | | | / / |

**Provider Information**

| | | |
|---|---|---|
| Name: | Telephone: | Fax: |
| Address: | | |

**Medicaid Identifying Information**

| | | | |
|---|---|---|---|
| TPI: | NPI: | Taxonomy: | Benefit Code: |

**CSHCN Identifying Information**

| | | | |
|---|---|---|---|
| TPI: | NPI: | Taxonomy: | Benefit Code: |

**FOR OFFICE USE ONLY:** Medicaid ☐ Yes ☐ No HMO ☐ Yes ☐ No Restrictions:

PAN# Valid To

**FORM TP-1**

Effective Date_07302007/Revised Date_06012007