

Upgrade Request Form

Attach documentation supporting the patient's current diagnosis and the reason for the upgrade request
Phone: (855) 825-7818 | Fax: (877) 583-6440

| | | | |
|---|---------------|------------------|---------------------|
| Facility Requesting Upgrade | | Contact Person | |
| Phone | | Fax | |
| <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> PT | | | |
| Patient's Name | | | Date of Birth |
| Member ID Number | Current Level | Requesting Level | Current Referral No |
| Current Diagnosis | | | Date of last visit |
| How many visits completed (dates) | | | |

FOR OFFICE USE ONLY

| | |
|----------------------|-----------------------|
| Date TN received fax | Date request reviewed |
| Referral History | |
| Recommended Level | |
| Comments | |

Additional Comments:

Not enough information received. Please send additional objective clinical information, including initial evaluation and treatment notes, for further review.

No upgrade at this time. Please continue to treat patient and send objective progress notes for further review. Your request will be reconsidered.

Confidentiality notice: the documents accompanying this transmission contain confidential information, belonging to the sender that is legally privileged. The information is intended only for the use of individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this telecopied information is strictly prohibited. If you have received this in error, please notify us by telephone immediately to arrange for the return of the original documents to us.