THERAPY NETWORK OF NEW JERSEY

PATIENT INTAKE FORM

☐ Routine
☐ Urgent (An expedited/urgent request is only warranted when applying the Standard Time frame for making a determination could seriously jeopardize the enrollees health, life, or ability to regain maximum function

Fax this request to 1-855-825-7820. This form must be filled out in its entirety.
For inquiries or status of pending requests, call: 1-855-825-7818 or visit the Provider Web Portal

PLEASE SUBMIT ONE FORM PER DISCIPLINE

Member ID Number	Member Health Plan		Member County
Member Last Name	Member First Name		Member Telephone Number
Member Date of Birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female		Request Date (mm/dd/yyyy)
Referring Provider Name	Phone Number	Fax Number	Referring Provider NPI
Facility/Group Name (Rendering Provider)			Facility/Group TIN Number
Facility/Group Address			Facility/Group NPI
City			State / Zip Code
Contact Person	Facility Phone Number		Facility Fax Number (Required for Fax Notifications)
Treating Therapist Last Name	Treating Therapist First Name		Treating Therapist NPI

Line of Business	Place of Service
☐ Medicare ☐ Medicaid ☐ Medicaid Healthy Kids	☐ Office (11) ☐ Member Home (12) ☐ Outpatient Hosp (22) ☐ Independent Clinic (49) ☐ Other [_ _]

Primary Diagnosis Description

ICD Code (s)	CPT Code(s)

If Status Post Surgery, List Procedure

Date of Surgery (mm/dd/yyyy)	For Cerebral Vascular Accident (CVA), list Date of CVA (mm/dd/yyyy)

☐ Please check box to confirm	☐ Please check box to confirm	☐ Please check box to confirm
Member's Plan of Care has been submitted and approved by ordering Provider and the frequency and duration are: _____ times/ per week _____ number of weeks _____ number of units	The servicing provider has reviewed the approved Plan of Care with the Enrollee, including the frequency and duration, and will provide these services.	Ordering Provider will be notified when therapy has been completed and whether the goals have been achieved (Member discharged) or Therapy was stopped.

FILL OUT SEPARATE PATIENT INTAKE FORM FOR EACH DISCIPLINE

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy	Evaluation Date (mm/dd/yyyy):	Test Used (Attach Test Scores)

Note/Comments

For school aged children, submit IEP, or reason for non-availability of IEP

I, the undersigned, hereby attest that the information provided above is accurate and truthful to the best of my knowledge and belief.

Provider or Authorized Representative Signature _____ Print Name _____ Date _____