THERAPY NETWORK OF PUERTO RICO

Patient Intake Form

Fax this request to: 1-800-615-0148

☐ **Routine** ☐ **Urgent** (An expedited/urgent request is only warranted when applying the standard timeframe for making a determination could seriously jeopardize the enrollee's health, life, or ability to regain maximum function)

This form must be filled out in its entirety. For inquiries or status of pending requests, visit the Provider Web Portal. **Please SUBMIT ONE FORM PER DISCIPLINE and include current medical order, evaluation & POC**

Member ID Number	Member Health Plan		Request Date (mm/dd/yyyy)
Member Last Name		Member First Name	
Member Telephone Number	Member Date of Birth (mm/dd/yyyy)		Sex ☐ Male ☐ Female
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	Zip Code	Contact Person Name	
Phone Number		Fax Number (Required for Fax Notifications)	
Treating Therapist Last Name	Treating Therapist First Name		Treating Therapist NPI
Line of Business: ☐ Medicare	Place of Service: ☐ Office (11) ☐ 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 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**	☐ Please check box to confirm The servicing provider has reviewed the approved Plan of Care with the Enrollee, including the frequency and duration, and will provide these services.	☐ Please check box to confirm 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 ☐ Aquatic Therapy ☐ Vestibular ☐ Lymphedema* * For Lymphedema Only: CPT codes, Frequency and Units Required. (This information needs to be added in the Note/Comments Section)	Evaluation Date (mm/dd/yyyy):	☐ Initial Review (1st Episode) ☐ Episode Number (2nd, 3rd, 4th ,etc): _____ ☐ Previous Eval Dates: _____

Note/Comments:

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 _____