



## PT or OT Initial Authorization Form

- Physical Therapy**
- Occupational Therapy**

**Fax this form to (716) 857-4694 or (800) 245-3370**

Patient/Member Information		
Member name:	Diagnosis:	ICD-9 Code:
Member ID number:	Prior PT/OT for this diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, enter date:
Member DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of onset or exacerbation:	Date of surgery (if applicable):	
Name of requesting physician:	Tax ID# or NPI#:	Phone:
<b>Check if applicable:</b> <input type="checkbox"/> Medicare <input type="checkbox"/> Workers' Comp <input type="checkbox"/> No-Fault		Date of injury:
Physical Therapist / Occupational Therapist Information		
PT/OT Facility	PT/OT Provider ID#:	
PT/OT Phone:	PT/OT Fax:	
Date of initial visit:		

**Note: If the member is returning for therapy in the same calendar year, we will require current clinical for review before the initial authorization can be approved.**

**Initial requests will only be backdated a total of five business days.**