



Member Name: _____ ID# _____ DOB _____

Medicare A B Other Insurance _____

Name of Nursing Home/ALF _____

EPSDT eligible member? Yes No CRS eligible member? Yes No

Service Provider Number: _____
(AHCCCS# of Provider referred to)

Service Provider Name: _____
(Name of Provider referred to)

IS TRANSPORTATION REQUIRED? Yes No

If yes, Provider Address: _____
(Complete ONLY if transportation is required)

Date of Service: _____ Appointment Time: _____

Diagnosis Code: _____

Requested CPT Code: _____ Est. Cost: _____

Service Requested: _____

URGENCY STATUS:

- Emergent (within 24 hours)
- Urgent (within 2 days)
- Routine (within 21 days)

AUTHORIZATION NUMBER _____
(For P/GLTC use only)

Evaluation and Treatment:

- Why is therapy evaluation being requested at this time? _____
- Why is Restorative nursing not sufficient for this problem?
(check one of the following for PT, OT, and ST request)
 - Skilled assessment necessary to develop a treatment plan for RNA
 - RNA has recently, or is currently seeing member and further invention is needed
 - Other _____
- Is there prior therapy for this problem, which indicated that the patient has reached his or her potential?
Yes No Comments: _____
- What problems or concerns do patient/staff have that has led to a request for evaluation: _____
- What is the expected goal of assessment/therapy? _____
- Is patient capable of following and remembering directions? Yes No
- Is patient willing to participate in therapy? Yes No
- Name and phone number of Therapist to contact for questions/clarifications: _____
- Duration and Frequency: _____

PCP/PCP Designee Signature _____