

**Outpatient Rehabilitation Therapy Authorization Request Form**

All boxes MUST be completed:

Member Name:	Member ID#:
Facility:	CCI Provider ID#:
Phone#:	Fax#:
Referring Practitioner's ID# (REQUIRED):	Referring Practitioner's Name:
Diagnosis CODE (REQUIRED):	Additional Diagnosis CODEs:
Type of Review (check one): <input type="checkbox"/> Initial Authorization (Pre-Service Claim)* <input type="checkbox"/> Additional Visits**	Date Span for Requested Services: _____ to _____
Total # of Visits Used to Date:	Date of First Visit for this Episode of Care:
Services Requested: <input type="checkbox"/> Physical Therapy # requested _____ <input type="checkbox"/> Occupational Therapy # requested _____ <input type="checkbox"/> Speech Therapy # requested _____	ConnectiCare to complete: #approved: _____ by: _____ #approved: _____ by: _____ #approved: _____ by: _____

- \* Required documents for Initial Authorization:  
 Admission Sheet / Face Sheet     Referring Practitioner's Script     Initial evaluation including goals
- \*\* Required documents for Additional Visits:  
 Progress toward goals/current treatment plan

Notification of completed care:

Date of Discharge: \_\_\_\_\_ Discharge Reason: \_\_\_\_\_

**Note: This authorization is subject to the terms and conditions of the member's benefit package, continued participation with ConnectiCare, and will be void if the member ends coverage.**

Fax this form to:

For ConnectiCare Commercial Members ..... (860) 674-5893 or 1-800-923-2882

For ConnectiCare VIP Medicare Plan Members ..... 1-866-706-6929

This form must be received 3-4 business days prior to the expiration date of authorization.