

**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) 678-5289 or 1-866-590-3187

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.