Geisinger

Outpatient Rehab Therapy Services Request Form

Complete and fax this authorization request form, including supporting clinical documentation to **(570) 271-5302**.

Still faxing? If so, you may be missing out on timesaving benefits, including automatic approvals and guided submissions only available when using the Cohere portal to manage authorizations. Registration only takes a few minutes, and unlocks access for all users at your practice organization. **Visit www.coherehealth.com/register to begin**.

Patient information

First name **required*

Last name **required*

Member ID **required*

Date of birth (MM/DD/YYYY) **required*

Submitter information

Submitter first name **required*

Submitter last name **required*

Submitter email **required if phone number not provided*

Submitter fax number

Submitter phone number **required if email not provided*

Diagnosis

Primary diagnosis code **required*

Secondary diagnosis code

Secondary diagnosis code

Service details

Start Date (MM/DD/YYYY) **required*

End Date (MM/DD/YYYY) **required*

Number of service dates **required*

Place of service (Choose one) **required*

- ◯ 11 - Office
- ◯ 19 - Off Campus-Outpatient Hospital
- ◯ 22 - On Campus-Outpatient Hospital
- ◯ 32 - Nursing Facility
- ◯ 62 - Comprehensive Outpatient Rehab. Facility
- ◯ Other _____

CPT/HCPCS **required*

CPT/HCPCS

CPT/HCPCS

CPT/HCPCS

CPT/HCPCS

CPT/HCPCS

CPT/HCPCS

CPT/HCPCS

CPT/HCPCS

CPT/HCPCS

Service category (Choose one) **required*

◯ Physical Therapy ◯ Occupational Therapy ◯ Speech Language Pathology ◯ Chiropractic

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Ordering provider

Name **required*

Billing street address

City | State | Zip code

National Provider Identifier (NPI) **required*

Provider Tax ID number (TIN) **required*

Fax number – –

Phone number – –

Performing facility

Name **required*

Performing street address

City | State | Zip code

National Provider Identifier (NPI) **required*

Provider Tax ID number (TIN) **required*

Fax number – –

Phone number – –

Expedite request

☐ Expedite request

In order for a case to be expedited the physician (or other clinician) must indicate that applying the standard timeframe could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. If the date of service is greater than 3 days in the future, please DO NOT submit this request as expedited.

Please provide physician (or other clinician) justification

Physician (or other clinician) signature

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Clinical assessment

1. Request type (Choose one) **required*

- ◯ Initial Therapy
- ◯ Concurrent Therapy

2. Other insurance (Choose one) **required*

- ◯ Workman's Comp
- ◯ Auto
- ◯ Not applicable

3. For PT & OT only - Does the patient have any of the following? (Choose all that apply) **required*

- ☐ Pain with motion
- ☐ Restricted joint motion
- ☐ Poor endurance
- ☐ Difficulty with mobility or ambulation
- ☐ Poor safety awareness
- ☐ Sensory processing deficits (vestibular, proprioceptive, tactile, visual, or auditory)
- ☐ Muscle spasms
- ☐ Impaired self-care/home management skills
- ☐ Muscular weakness due to neurologic, muscular, skeletal abnormalities or trauma
- ☐ Loss of gross and fine motor coordination
- ☐ Abnormal muscle tone (rigidity or flaccidity)
- ☐ Impaired cognitive skills (attention, memory, problem solving) resulting from head trauma or neurologic events who have potential for improvement or restoration
- ☐ Ability is not expected to improve (excluding the establishment of a maintenance therapy program)
- ☐ None of the above

4. For SLP only - Does the patient have any of the following? (Choose all that apply) **required*

- ☐ Abnormal characteristics of speech
- ☐ Decreased speech fluency or sound production (e.g. articulation, phonologic process, apraxia, dysarthria)
- ☐ Impaired language skills (e.g. morphology, syntax, semantics, pragmatics)
- ☐ Impaired communication skills (receptive and/or expressive) in oral, written, graphics, and manual modalities
- ☐ Difficulty swallowing and/or oral function for feeding
- ☐ Impaired auditory function
- ☐ Impaired cognitive function (e.g. learning ability, memory, working memory, abstract thought, language, and attention)
- ☐ Impaired sensory processing
- ☐ None of the above