Prior Authorization Form

Please Fax To (952)853-8714 For Questions Call (888) 467-0774

Habilitative Therapy Review Request

Member and Provider information	
Member Name:	Provider:
Member ID #:	Address:
DOB:	Tax ID #:
Form Completed By:	Phone #:
Date:	Fax #:

Referring MD (first & last name):_____

MD Clinic: _____ Phone:_____ Fax:_____

ICD9:_____Diagnosis:_____

Call Member Services for benefit information: 1-800-883-2177 Does member have benefit limit? NO / YES If Yes, # of visits allowed: ____

Visit Information:

Number of Visits completed January 1 through request date for: PT____ OT____ ST_____

Date evaluation / re-evaluation completed: _____

PT # of visits_____ Frequency of visits_____ x/week Dates: _____to _____

OT # of visits_____ Frequency of visits_____ x/week Dates: _____to _____

ST # of visits_____ Frequency of visits_____ x/week Dates: _____to _____

Pool # of visits_____ Frequency of visits_____ x/week Dates: _____to _____

Documents to include with this Request:

- **Standardized test scores completed in the last 3 months**
- **Goals, treatment plan and (if applicable) a progress report**
- **Signed Physician order**

Comments:

CoOportunity Health has contracted with HealthPartners Administrators, Inc. to provide claims processing, medical management and certain other administrative services.