Universal PT/OT/Speech Prior Authorization Form – BabyNet

Information below must be provided to obtain an authorization for BabyNet therapy services rendered by private therapists. For questions, contact the plan at the associated phone number.

***Fax the COMPLETED form OR call the plan with the requested information.**

☐ **Absolute Total Care**
P: 803-933-3638
F: 866-918-4451
www.absolutetotalcare.com

☐ **BlueChoice HealthPlan**
P: 866-902-1689
F: 800-823-5520
www.bluechoicescmedicaid.com

☐ **Carolina Crescent Health Plan**
P: 866-748-8661
F: 877-251-6649
www.carolinachp.com

☐ **First Choice by Select Health**
P: 888-559-1010
F: 866-368-4562
www.selecthealthofsc.com

☐ **Unison Health Plan**
P: 800-366-7304
F: 866-841-9336
www.unisonhealthplan.com

Patient's Name _____ DOB _____
First Middle Last

Address (Street, Apt.#) _____ City/State/Zip _____

Phone(s) _____ Medicaid Number _____

Parent/Guardian Name _____ Relationship _____
First Middle Last

Primary Coverage:
Plan _____ ID# _____ Group #_____

Policy Holder _____ DOB _____ Relationship to patient _____ Employer _____

Clinical

Type of Therapy: ☐ Physical ☐ Occupational ☐ Speech Initial Diagnosis/ ICD9 CODE: _____

CPT Code: _____ Therapy Initiation Date: _____Place of Service: _____

Therapy Frequency: _____ times per WEEK / MONTH (circle one) Number of WEEKS / MONTHS (circle one): _____

Supporting Documentation

The documentation below is required before an authorization may be issued. Identify the documentation attached to this request for authorization by placing an X in the appropriate box.

☐ Current Physician's Order ☐ Initial Therapist Evaluation ☐ Current Therapist Evaluation (if applicable)

☐ Progress Records to Date ☐ Statement Describing the Patient's Deficits, Treatment, and Goals

Therapist Name:_____ NPI:_____

Therapist Phone: _____ Fax: _____

Form Completed by: Name _____Phone:_____

Plan Point of Contact: _____ Request Date: _____ Time of Request: _____
Plan Reference/Confirmation Number: _____

FOR MCO USE ONLY:

☐ Approved ☐ Denied Authorization # _____ Date of Notification: _____

Reviewer(s) name & title: _____

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered and are subject to benefit plan limits.