



Fax this form with all applicable information documented to: **1-833-719-1607**.
A review can NOT be completed without the necessary information.

Instructions on next page.

Contract Number (include prefix)	Group Number	Subscriber Name (last, first, middle initial)	
Patient Name (last, first, middle initial)	Date of Birth	Ordering Provider's Name (first and last)	
Ordering Provider National Provider Identifier (NPI)	Address of Ordering Provider		
Therapist Name	Therapist NPI	Therapist Office Phone Number	Therapist Office Fax Number
Therapist Facility Name	Therapist Facility Address		Therapist Email Address
Primary Diagnosis Code (do not use "V" codes)	Onset Date	Secondary Diagnosis Code* (do not use "V" codes)	Onset Date

Check All that Apply:

Surgery ☐ Yes ☐ No **Date of Surgery:** _____ **Type of Surgery:** _____
Injury ☐ Yes ☐ No **Date of Injury:** _____ **Type of Injury:** _____

Has patient had previous therapy for this condition? ☐ Yes ☐ No **If yes: Date:** _____

List medical or surgical complications and date related to current treatment: _____

LIST ALL DATES OF SERVICE FOR THE CURRENT CALENDAR YEAR:

1	2	3	4	5	6	7	8
9	10	11	12	13	14	15	

☐ **Initial Certification**

_____ Copy of initial evaluation _____ Current MD Order _____ Last 5 treatment notes/exercise flow sheets
_____ Current ordering provider current reassessment with objective findings, updated goals, progress toward goals, current treatment plan, including frequency/duration – **performed at 15th visit**
Number of visits requested for this certification _____
Projected end date of therapy _____
_____ **Justify the need for continuation of therapy.**

☐ **Additional Certification**

_____ Current ordering provider _____ Current MD Order
_____ Treatment notes from previously certified visits, exercise flow sheets. Documentation should include objective findings/functional limitations and any additional information from last certified visit to support medical necessity for additional visit.
Number of visits requested for this certification _____
Projected end date of therapy _____
_____ **Document changes in treatment plan and/or the patient's condition to warrant the course of treatment.**

☐ **Appeal**

_____ Submit any additional documentation/information to support medical necessity of continuation of skilled therapy.

Instructions for completing the OCCUPATIONAL THERAPY PRECERTIFICATION REVIEW

Print legibly.

1. **Contract Number:** Enter Credence contract number. **Prefix of contract number must be included.**
2. **Group Number:** Enter group number located on patient's Credence identification card.
3. **Subscriber Name:** Enter name of contract holder from Credence identification card. Enter last name, followed by first name and middle initial.
4. **Patient Name:** Enter patient's last name, followed by first name and middle initial.
5. **Date of Birth:** Enter patient's date of birth, include month, date and year.
6. **Ordering Provider's Name:** Enter first and last name of ordering provider.
7. **Ordering Provider NPI:** Enter the ordering provider's NPI.
8. **Address of Ordering Provider:** Enter street address of ordering provider, including city, state and zip code.
9. **Therapist Name:** Enter name of licensed physical therapist providing the care.
10. **Therapist NPI:** Enter the NPI of licensed physical therapist providing the care. If the physical therapist is hospital-based, enter the hospital's NPI.
11. **Therapist Office Phone Number:** Enter the telephone number, including area code, of physical therapist's office.
12. **Therapist Office Fax Number:** Enter fax number, including area code, of physical therapist's office.
13. **Therapist Facility Name:** Enter name of facility where physical therapy is to be performed.
14. **Therapist Facility Address:** Enter address of facility where physical therapy is to be performed, including city, state and zip code.
15. **Therapist Email Address:** Enter email address of physical therapist at facility where physical therapy is to be performed.
16. **Primary Diagnosis Code:** Enter diagnosis code of diagnosis for which patient is being treated and the onset date.
Do not use "V" codes. **All diagnoses should be specific to at least the 4th digit (i.e., 724.0).**
17. **Secondary Diagnosis Code:** Enter any other diagnosis codes that pertain to patient, **specific to at least the 4th digit (724.0) and the onset date.**
18. **Surgery:** Check Yes or No.
19. **Date of Surgery:** Enter the date surgery was performed.
20. **Type of Surgery:** Enter the type of surgery performed.
21. **Injury:** Check Yes if patient sustained an injury prior to or during therapy.
22. **Date of Injury:** Enter onset date of injury.
23. **Type of Injury:** Enter the type of injury sustained.
24. **Has patient had previous therapy for this condition?** Check Yes if patient has received prior therapy for same condition at your facility or another facility and enter dates of prior therapy.
25. **List medical or surgical complications and date related to current treatment:** Enter any complications the patient has sustained and the date the complication occurred.
26. **List all dates of service for the current calendar year:** Prior to each precertification/recertification, provider should verify contract benefits to determine number of visits required prior to certification requests.
In addition to this form, please fax medical records for the initial evaluation; the last five treatment notes and exercise flowsheets, therapy order, plans and goals; and current reassessment, if applicable.
27. **Initial Certification:** Check this box if this is the first request for additional visits.
28. **Additional Certification:** Check this box if requesting additional visits after the initial request.
29. **Appeal:** Check this box if you have received notification of non-certification of additional visits and are requesting an appeal.

To request an expedited appeal for this patient/member, submit any new/additional clinical indicators to support the medical necessity of continuation of skilled therapy. The appeal process will begin when all clinical information necessary to make a review determination is received. The entire medical record is not needed for the expedited appeal.