THERAPY PRIOR AUTHORIZATION FORM

INSTRUCTIONS: Please fax the following information to Children's Mercy Pediatric Care Network **888-670-7260**. CMPCN will verify benefits, eligibility, and provider network status and make you aware of non-covered services.

Within 48 hours or two business days CMPCN will call you with a determination or inquiry for additional information. Authorization numbers issued for covered services should be included on claims submitted.

Payment is subject to eligibility status and benefits that are in effect at the time services are provided. CMPCN will not assume financial responsibility for services where prior notification does not occur according to CMPCN policies. You must notify CMPCN if additional services or an extension is required.

PLEASE CHECK ONE: _____Initial request _____Extension of service*

***Prior Authorization #_____ (if request is for an extension of services)**

Date Form Completed	Member NAME
Requesting Provider's Name	Member ID# and DOB
Provider of Therapy Service	Service Start Date / Diagnosis

THERAPY REQUESTED:

TYPE	FREQ / Week	Estimated Duration	Length of visit/day
Physical Therapy			
Occupational Therapy			
Speech Therapy			
Date of initial evaluation:			
DOES THE MEMBER HAVE AN IEP or IFSP? _____YES**_____NO **IF YES PROVIDE A COPY WITH THIS REQUEST			

Location of service	Home	Office	Outpatient hospital	Rehab center	

EVALUATION:

Functional Impairment; Including Percent if Developmental Delay:

- Limitations: _____MILD _____MODERATE _____SEVERE

_____

***Include copies of; initial evaluation, Plan of Care, IEP/IFSP (if applicable) and progress notes if extension is requested.**

YOUR CONTACT NAME_____YOUR CONTACTPHONE_____