Outpatient Therapy Prior Authorization Request Form

Please attach documentation to support medical necessity for the services requested.

Fax To: 1-888-656-1952 **# of pages _____**

Request Date: _____ Member Name: _____

Member DOB: _____ UCare Member ID:_____

Ordering/Referring Provider Name: _____ NPI:_____

Ordering/Referring Provider Address:_____

Ordering/Referring Provider Phone #: _____ Fax #:_____

Service Facility Name:_____ Participating: Y ☐ N ☐

UCare Provider ID: _____ Billing NPI:_____

Therapy Provider Contact Name: _____ Billing Tax ID: _____

Therapy Provider Phone #:_____ Therapy Provider Fax #:_____

Type of Therapy: ☐ PT ☐ OT ☐ ST

Description: _____

Diagnosis: _____ CPT/HCPCS: _____

Number of Units/Visits Requested: _____

Date(s) Requested: _____

Place of Service

☐ Office (11)
☐ Home (12)
☐ Outpatient Hospital (22)
☐ Nursing Facility (32)
☐ CORF (62)
☐ Other:_____