

Therapy Information Request Form

From _____	Phone _____
Reference number _____	Fax _____
Pages (including cover sheet) _____	Comments _____

Please see the information form below. This information is required in order to review the requested procedure against the medical policy. The information will assist us in providing a timely determination of coverage for your patient's request.

An accurate decision cannot be made without this information. Please complete document or ensure clinical includes information noted below and upload to the NYCE PPO portal at nyceppo.com.

[UnitedHealthcare Commercial Medical & Drug Policies](#)

Patient full name _____	Date of birth _____
Member ID _____	MM/DD/YYYY

Please include:

- Current clinical information and relevant patient history (signs/symptoms/surgery)
- Therapy evaluation
- Goals (current progress report if ongoing therapy)
- Name of ordering MD and MD order if applicable
- Facility information

For each requested therapy, please indicate the below information:

- The therapy and code(s) being requested (physical therapy, occupational therapy, speech therapy)
- Start date of current request (for additional visits-please put the new/concurrent start date, not the date of initial request)
- Number of visits being requested
- Number of visits previously used

Therapy requested _____

Start date of current request _____
MM/DD/YYYY

Number of visits being requested _____

Number of visits previously used _____