healthfirst
Health Insurance for New Yorkers

Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy Prior Authorization Request

Please fax to Healthfirst at **1-646-313-4603**

Date: # of Pages:

Instructions

1. Use this form when requesting prior authorization of physical, occupational, or speech therapy services for Healthfirst members.
2. Please complete and fax this request form along with all supporting clinical documentation to Healthfirst at **1-646-313-4603**.
3. For help completing this form, please contact Healthfirst Provider Services at 1-888-801-1660.
4. For a faster response, please use the Online Authorization tool on the Healthfirst Provider Portal at **hfproviderportal.org**. To create an account, select Create your account, or contact your Healthfirst Network Account Manager.
5. Please PRINT, in black ink, one character per box for ALL requested information and completely fill in each circle for selection where applicable.

NOTE: The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material.

If you receive this material/information in error, please contact the sender and delete or destroy the material/information.

Patient Information

Healthfirst Member ID Number		OR Medicaid Member ID Number
First Name	Last Name	Date of Birth

Requesting Provider Information

Provider or Facility Name	National Provider Identifier (NPI)	Tax ID Number
Address		
City	State	Zip
Phone Number	Fax Number	

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Servicing Provider Information		
Provider or Facility Name	National Provider Identifier (NPI)	Tax ID Number
Address		
City	State	Zip
Phone Number	Fax Number	

Request Information			
Initial Evaluation Date:	Date of Last Therapy Visit:	No. of Therapy Visits to Date:	No. of Visits Being Requested:
Service Type: ◯ Physical Therapy	PT Diagnosis Code (ICD-10 format)		
Service Type: ◯ Occupational Therapy	OT Diagnosis Code (ICD-10 format)		
Service Type: ◯ Speech Therapy	ST Diagnosis Code (ICD-10 format)		

Request For:

- ◯ Onset (commencement) of Therapy Services
- ◯ Extension of Therapy Services
- ◯ Existing Case, New Injury or Condition
- ◯ Existing Case, New Episode or Recurrence
- ◯ Other Procedure

Request Type:

◯ Office ◯ Outpatient Hospital

NOTE: For concurrent reviews, please attach to this fax clinical notes, including the initial evaluation, all follow-up notes dated within the last three months with patient's symptoms, exam findings, all prior conservative management, documentation of surgical plan, and related imaging reports dated within the past 12 months.

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