

## Section I — Submission

## Section II — General Information

### Section III — Patient Information

## Section IV – Provider Information

Section V – Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD Code)☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other (specify) \_\_\_\_\_

☐ Physical Therapy   ☐ Occupational Therapy   ☐ Speech Therapy   ☐ Cardiac Rehab   ☐ Mental Health/Substance Abuse

Number of sessions	Duration	Frequency	Other
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☐ Home Health (MD signed Order attached? ☐ Yes ☐ No) (Nursing Assessment attached? ☐ Yes ☐ No)

Number of visits requested	Duration	Frequency	Other
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☐ DME (MD signed order attached? ☐ Yes ☐ No) (*Medicaid only:* Title 19 Certification attached? ☐ Yes ☐ No)

Equipment/supplies (Include any HCPCS Codes)	Duration

## Section VI – Clinical Documentation (See Instructions Page, Section VI)

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