Outpatient Therapy Authorization Request Form

Please attach this completed form to your clinical documentation and signed plan of care

Fax cover sheet, completed request form and clinical documentation to **813-321-7220**
OR submit with request online via Availity.

Contact at providers office:	Secure fax #:
Name of requesting provider:	Phone #:
Note: Please provide appropriate contact information, including best working phone number for Humana staff to contact you if clarification or additional information is needed to complete the request.)	

Member Information	
Last Name:	First Name:
Humana ID:	DOB:
Authorization Reference # (if applicable):	

Diagnosis Code(s) & Dates of Service (DOS)			
ICD 10:	ICD 10:	ICD 10:	ICD 10:
Start date of service:		End date of service:	
Date of last therapy evaluation or reevaluation/recertification:			
Type of request: ☐ Initial Request ☐ Additional/Continued Therapy Request			
Type of therapy being requested (only choose **1** option): ☐ Physical ☐ Occupational ☐ Speech			
Place of Service/Setting (only choose **1** option): ☐ OP Facility ☐ Home ☐ School-Based* *If services are normally offered in a school-based setting, please verify whether the school system can provide the service or include corresponding clinical information as to why requested services are medically necessary to be covered under the Medicaid benefit.			
Attach/submit a copy of the therapy evaluation/reevaluation and signed plan of care (signed by MD, DO, PA, or APRN) with **each** request.			

Humana
Healthy Horizons®
in Florida

FLHLPMZEN0722

Procedure Code(s)					
Code:	Units (1 unit is 15 minutes) for	times a week for	weeks	Total # of visits:	
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Any additional pertinent information: