



Completion Guide Occupational Therapy Authorization Form

The following guide is intended to assist you in completing the *USFHP Occupational Therapy Authorization Form*.

Demographics (items 1, 2, 5): Please provide the member's full name, US Family Health Plan identification number including Suffix and the member's date of birth.

Facility /Provider info (items 8, 9, 10, 11): Please provide the name, provider ID, telephone number and fax number of the treating provider. This will ensure that the Occupational Therapy Reviewer can contact you if additional information is needed. Authorization numbers and dates can be faxed to your attention.

Date of illness/injury (item 3): The date of the onset of the illness, injury or surgery is helpful to the reviewing therapist in determining availability of the short-term rehab benefit.

Diagnosis (item 6, 7): All requests should include the diagnosis and ICD-9 code for the primary diagnosis being treated.

Number of visits requested (item 15): please request the number of visits you project to complete the entire treatment plan beyond the initial 30 visits.

Date of start of care / Discharge Date (items 16, 17): Please fill in all applicable dates to indicate anticipated length of treatment.

Previous Rx for this diagnosis (item 12): Indicate previous treatment either at your facility or another provider.

Initial/Previous Clinical Assessment (item 18): Please report specific pertinent objective measurements for all affected areas. In the case of multiple diagnoses, applicable data for all pertinent diagnoses should be on one USFHP Occupational Therapy Authorization Form.

Current Clinical Assessment (item 19): As described in item 18 above, please provide information regarding the clinical status after 8 initial visits.

Current Functional Status (item 20): Rate the member's current functional limitations using the 1-4 scale provided. Please indicate any premorbid deficits.

Current Treatment Plan (item 21): Based on the intensity and frequency of service, please include instruction for the HEP in report.

Current Clinical Goals/Functional Outcomes (items 21, 22): Based on the severity of illness, please be specific in listing goals and outcomes as they relate to Clinical and Functional Assessments reported.

Note: The Clinical Review Department cannot perform retroactive reviews, therefore any requests for authorization of visits performed more than 7 days prior to receipt of request in Clinical Review must be submitted to Provider Appeals Department for authorization. It is not necessary to submit pages of evaluation and progress notes unless we request it. We need only the *USFHP Occupational Therapy Authorization Form* completed in full.

ATTACHMENTS

[Attachment A:](#) ICD-9 Codes Not Covered for Physical, Occupational and Speech Therapy

[Attachment B:](#) ICD-9 List of Non-specific ICD-9 Codes that are Not Covered for Physical, Occupational, and Speech Therapy.

Occupational Therapy Authorization Form



Ongoing coverage beyond 30 visits from initial treatment visit
 Fax to the Clinical Review Department (617-972-9409)

1. Member Name:	2. DOB:	3. DOI	4. Date of Report:																																																																		
5. Member ID#:	6. Dx:	7. ICD-9:																																																																			
8. Facility Name:	9. Tufts Health Plan Facility ID #:	10. Facility Phone #:	11. Facility Fax #																																																																		
12. Previous Rx for this Dx? Yes <input type="checkbox"/> No <input type="checkbox"/>	13. Any other Dx? Yes <input type="checkbox"/> No <input type="checkbox"/>	16. Start of Care	17. Est D/C Date:																																																																		
14. Total Visits Since Start of Care:	15. # of Visits Requested:																																																																				
18. INITIAL/PREVIOUS CLINICAL STATUS		19. CURRENT CLINICAL STATUS																																																																			
		20. CURRENT FUNCTIONAL STATUS																																																																			
A. Pain Intensity: 0/10-10/10 B. ROM: C. Strength: D. Alignment: E. Ambulatory Status/ Balance: F. Sensory/Reflexes: G. Coordination		A. Pain Intensity: 0/10-10/10 B. ROM: C. Strength: D. Alignment: E. Ambulatory Status/ Balance: F. Sensory/Reflexes: G. Coordination																																																																			
Please use this scale for 1-4 (1: Fully Able 75-100% 2: 50-75% 3: 25-50% 4: 0-25%)																																																																					
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