



Authorization Request Form - Part 2

Home Health, Speech Therapy, Physical Therapy, Occupational Therapy

Complete and fax the clinical worksheet immediately following the authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

Please fill in each question option completely →

Patient Information

First name	Last name
Member ID	Date of birth (MM/DD/YYYY)

Fill out the following section if submitting for any of the following: **Stroke: Speech Therapy**

Question 1

Have any of the following findings been documented in a recent encounter related to a recent stroke?

- | | |
|---|---|
| <input type="checkbox"/> Documentation of any speech delay or speech disorder | <input type="checkbox"/> Cognitive Impairment |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Difficulty chewing food | |

Fill out the following section if submitting for any of the following: **Stroke: Physical Therapy & Occupational Therapy**

Question 1

Has the patient had a recent stroke?

- Yes No

Question 2

Which of the following findings were documented at the most recent encounter?

- | | |
|---|--|
| <input type="checkbox"/> Neck pain, weakness, or limited motion | <input type="checkbox"/> Wrist pain, weakness, limited motion |
| <input type="checkbox"/> Back pain, weakness, or limited motion | <input type="checkbox"/> Hip pain, weakness, limited motion |
| <input type="checkbox"/> Shoulder pain, weakness, or limited motion | <input type="checkbox"/> Knee pain, weakness, limited motion |
| <input type="checkbox"/> Elbow pain, weakness, or limited motion | <input type="checkbox"/> Foot / Ankle pain, weakness, limited motion |
| <input type="checkbox"/> Hand pain, weakness, limited motion | <input type="checkbox"/> Finger pain, weakness, or limitation of motion |
| <input type="checkbox"/> Vertigo or Poor Balance | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Hand pain, weakness, limited motion | <input type="checkbox"/> Inability to perform activities of daily living or instrumental activities of daily living with a significant chance of improvement with occupational therapy |
| <input type="checkbox"/> None of the above | |

Fill out the following section if submitting for any of the following: **Stroke: Home Health**

Question 1

Does the patient live with those unable to care for the patient?

- Yes No

Question 2

Is the patient confined to the home, or the condition is such that leaving the home for required services would require considerable effort or expose the individual to undesirable risk?

- Yes No