



INITIAL THERAPY AUTHORIZATION FORM

PATIENT NAME _____ DOB _____

PASSPORT ID# _____ ORDERING MD _____

DIAGNOSIS _____

_____ NEW REQUEST or _____ DATE INITIAL THERAPY STARTED W/ PHP

PT _____ STATE DATE _____ TIME/WEEK _____ #OF WEEKS _____

OT _____ STATE DATE _____ TIME/WEEK _____ #OF WEEKS _____

ST _____ STATE DATE _____ TIME/WEEK _____ #OF WEEKS _____

INJURY/ACCIDENT/DATES:

Note any therapy provided by 1st Steps or the school system, type, and frequency.

Note and previous therapy received, type, frequency, dates and provider.

Requesting Provider _____

Provider ID# _____ Contact Person _____

Phone# _____ Fax# _____

SERVICES APPROVED: PHP TO COMPLETE

Total Visits _____ Times/Week _____ #/Weeks _____

Authorization# _____ Date of Service Approved _____ to _____

Date Authorized _____ By _____



INITIAL THERAPY AUTHORIZATION FORM

NAME _____

DATE OF EVAL _____

HISTORY AND PHYSICAL

SUMMARY OF CURRENT STATUS

RECOMMENDATIONS/TREATMENT PLAN



CONTINUED INITIAL THERAPY AUTHORIZATION FORM

PATIENT NAME _____ DOB _____

PASSPORT ID# _____ ORDERING MD _____

DIAGNOSIS _____

_____ NEW REQUEST or _____ DATE INITIAL THERAPY STARTED W/ PHP

PT _____ STATE DATE _____ TIME/WEEK _____ #OF WEEKS _____

OT _____ STATE DATE _____ TIME/WEEK _____ #OF WEEKS _____

ST _____ STATE DATE _____ TIME/WEEK _____ #OF WEEKS _____

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