Amerigroup

Medicaid

https://provider.amerigroup.com/TX

Therapy Request Form

Return this form via fax to **844-756-4608**. Clinical information is required with submission. If submitting a request via our provider website, attach clinical information along with this request form.[1]

Member information			
Member name:			
Date of birth:		Phone number:	
Medicaid/CHIP ID number:		Member ID number:	
Diagnosis code(s):		Date of onset:	

Date of therapy evaluation or re-evaluation					
Physical therapy (PT):		Occupational therapy (OT):		Speech therapy (ST):	
Place of service: ☐ Office — 11 ☐ Patient home — 12 ☐ Outpatient hospital — 22 ☐ Comprehensive outpatient rehabilitation facility — 62 ☐ Other:					

Therapy provider information			
Name:		Contact name:	
NPI:		TIN:	
Phone number:		Fax number:	
Is member receiving the same type of therapy services from another provider or school now or in the past year? ☐ Yes ☐ No		If yes, indicate provider/school/early intervention specialist name and include service, diagnosis, frequency, and duration:	

Ordering physician information A physician order must accompany every request. Accepted physician orders include facility discharge orders, written orders, verbal orders, and electronic orders.			
Ordering physician name:		Date of last visit:	
Ordering physician phone number:		Ordering physician fax:	
Ordering physician NPI:		Ordering physician TIN:	
If ordering physician is out-of-network, provide address information:			

* Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup.

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

Therapy service request is: ☐ Initial ☐ Ongoing services ☐ Acute ≤ 60 days ☐ Developmental delay (DD) ≤ 90 days				
	CPT®/CMS code and applicable modifier(s)	**Frequency (either per week or per month)**	**Number of visits requested**	**Date(s) of service (no earlier than the fax date)**
PT				
OT				
ST				
ST DD	Has member had a hearing test? ☐ Yes ☐ No	If yes, the results were: ☐ Normal ☐ Abnormal	Year completed:	
	For an abnormal hearing test, description of physician treatment plan:			

DD/anomalies for PT/OT/ST: For initial and ongoing services, provide standardized test scores every six months.

Standardized test used:		Standardized scores:	

For all ongoing therapy requests, the following information must be included:

Overall percentage of goals met to date:		Anticipated date that therapy treatment plan will be completed:	
☐ Attendance record with date and duration of each session must be included in the clinical information and is submitted. ☐ Barriers for meeting goals or attending regular sessions are included in the clinical information. ☐ Update on progression of home exercise program is included in the clinical information.			

This request is not a guarantee of payment. All services are subject to any and all plan provisions, limitations, and patient eligibility at the time services are rendered.

1 The Availity Portal* at **www.availity.com** can be used to request therapy prior authorizations and to find information on a request previously submitted via phone, fax, or online tool.

Please contact Provider Services at **800-454-3730** for questions regarding utilization management for therapy services.