Outpatient Therapy Authorization Request Form

To create a new referral or authorization online, visit Availity.com. Providers can also fax a completed request form to **833-558-9712.**

Please attach this completed form to your clinical documentation and signed plan of care prior to submitting for review.	
Contact at provider office:	Secure fax:
Name of requesting provider:	Phone:
Note: Please provide your preferred contact information in case Humana needs to contact you if clarification or additional information is needed to complete your request.	

Member information	
Last name:	First name:
Medicaid ID:	Date of birth:
Authorization reference number (if applicable):	

Referring provider	
Name:	
National provider identifier (NPI):	OHCA ID:
Address:	
Phone:	Fax:

Treating provider	
Name:	
NPI:	OHCA ID:
Address:	
Phone:	Fax:

Humana Healthy Horizons in Oklahoma | SoonerSelect

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Diagnosis code(s) and dates of service (DOS)			
ICD-10:	ICD-10:	ICD-10:	ICD-10:
Start DOS:		End DOS:	
Date of last therapy evaluation or re-evaluation/re-certification:			
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):		☐ Outpatient facility	☐ Home
Have you previously seen this patient?		☐ Yes	☐ No
If yes, how many unit were previously approved?		How many units were used?	
Please note: Attach/submit a copy of the signed clinical order (signed by M.D., D.O., or APRN) for each request.			

Procedure code(s)		
Code:	_____ Units (1 unit is 15 minutes) for ____ times a week for ____ weeks	Total visits:
		Total units:
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Additional pertinent information: