Outpatient Therapy Authorization Request Form

Please attach this completed form to your clinical documentation and signed plan of care.

Fax cover sheet, completed request form and clinical documentation to **1-833-974-0059**
OR submit with request online via **Availity**.

Contact at provider's office:	Secure fax:
Name of requestor:	Phone:
Please note: Provide appropriate contact information, including best working phone number for Humana staff to contact you if clarification or additional information is needed to complete the request.	

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

Requesting provider/facility		
Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Treating/servicing provider		
Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Diagnosis code(s) and dates of service (DOS)			
ICD-10*:	ICD-10*:	ICD-10*:	ICD-10*:
Start date of service:		End date of service:	
Date of last therapy evaluation or reevaluation/recertification:			
Type of request: ☐ Initial request ☐ Additional/continued therapy request			

Humana
Healthy Horizons®
in Louisiana

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Diagnosis code(s) and dates of service (DOS)			
Type of therapy requested (only choose **1** option):	☐ Physical	☐ Occupational	☐ Speech
Place of service/setting (only choose **1** option):	☐ Outpatient facility	☐ Home	☐ School-based†
Attach/submit a copy of the therapy evaluation/reevaluation and signed plan of care (e.g., signed by a medical doctor, doctor of osteopathy, etc.) with **each** request.			

* International Classification of Diseases, Tenth Edition.

† If services are normally offered in a school-based setting, please verify whether the school system can provide the service, or include corresponding clinical information as to why requested services are medically necessary to be covered under the Medicaid benefit.

Procedure code(s)				
Code:	Units (1 unit is 15 minutes) for	times a week for	weeks	Total No. of visits: Total No. of units:
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Any additional patient information: