



Is There Other

Insurance?

No  Yes If yes,

Member ID:

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List \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Reason for continuing treatment:

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Is this request relating to post-surgical care?  No  Yes If yes, date & type of surgery: \_\_\_\_\_

ICD-9 Code(s) & Description:

Principal: \_\_\_\_\_

Secondary: \_\_\_\_\_

***Fax Initial / Re-evaluation report and up-to-date progress notes along with this completed form to support the following:***

Functional Level:

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Assessment of change in patient condition since last visit:

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Treatment Plan:

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List quantifiable & attainable treatment goals:

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Expected outcome: \_\_\_\_\_

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Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST.

In order to process your request, the Provider TIN & Fax #'s along with the CPT/HCPS & ICD-9 codes must be included.

Complete this form and attach copies of pertinent medical documentation or copies of the physician's actual office chart to support your request. Fax completed form to (646) 473-7447.

The Fund's Pre-Authorization Call Center is available Monday to Friday, 9:00 AM to 5:00PM at (646) 473-7446.

Pre-authorization requirements are regularly updated and are therefore subject to change; periodically visit the website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) for our most recent pre-authorization requirements, authorization request forms and other pertinent information located in the “For Providers” section.

\*Physical therapy, occupational therapy, speech/language pathology services.