



PHYSICAL MEDICINE RETRO AUTHORIZATION REQUEST

CONTACT / REQUESTOR INFORMATION:

Contact Name _____ Phone # _____ Ext _____

HP / MEMBER INFORMATION:Health Plan Name HMSA Member ID _____

Member Last Name _____ First Name _____ DOB _____

TREATING PROVIDER INFORMATION:

Treating Provider Name _____

Treating Provider Address _____

Treating Provider Phone _____ Fax _____

Treating Provider TIN _____ NPI _____

PLACE OF SERVICE INFORMATION:

<input type="checkbox"/> Office	<input type="checkbox"/> Group Home	<input type="checkbox"/> Outpatient Hospital
<input type="checkbox"/> Patient Home	<input type="checkbox"/> Mobile Unit	<input type="checkbox"/> Independent Clinic
<input type="checkbox"/> Assisted Living Facility		

RETRO DATES OF SERVICE: _____ **# VISITS:** _____**REASON FOR REQUEST OUTSIDE THE 10-BUSINESS DAY GRACE PERIOD:**

CAUSE OF THERAPY (circle): Traumatic Repetitive Work-Related Motor Vehicle Unspecified**DISCIPLINE TYPE (circle):** Physical Therapy Occupational Therapy Chiropractic

Initial Evaluation Date _____ Primary ICD 10 Dx code _____

Other ICD 10 Dx Codes _____

CLINIC INFORMATION:

Treating Provider/Clinic Name _____

Address _____

Clinic TID _____ Clinic NPI _____ Phone _____

Email completed form via SECURE email to: HMSAProviderConcerns@Evolent.com**IMPORTANT: Please attach clinical documentation to RadMD case once created**