Dell Children's Health Plan Therapy Request Form

dell children's HEALTH PLAN

Return by fax to 1-844-756-4608. If submitting request via our provider website, attach with clinical information.

Member information			
Member name:	Date of birth:	Phone number:	
Medicaid/CHIP ID number:	Dell Children's Health Plan 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 ☐ Other:
☐ Comprehensive outpatient rehabilitation facility — 62

Therapy provider information		
Name:	Contact name:	
Dell Children's Health Plan number:	NPI:	Texas Provider Identifier (TPI) number:
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.

In-network ordering physician name:	Date of last visit:
Ordering physician phone number:	Ordering physician fax:
Ordering physician NPI:	Ordering physician TPI number:
If ordering physician is out-of-network, indicate reason:	

Therapy service request is: ☐ Initial ☐ Ongoing services ☐ Acute ≤ 60 days ☐ Developmental delay (DD) ≤ 90 days

	CPT/CMS code and applicable modifiers	**Frequency (either per week or per month)**	**Number of visits requested**	**Dates of service (no earlier than 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.