



**Missouri Care**  
AN AETNA HEALTH PLAN

Prior Authorization Department  
Phone: 1-800-322-6027  
Fax: 1-866-946-2052

### Request and Justification for Therapy Services

Completion of this form is required to request prior authorization for physical, occupational or speech therapy.

A copy of the treating physician's order must be attached.

Authorization number

Ordering Physician

Diagnosis Code(s)

CPT/Billing Code(s)

#### Rehab Provider information

Rehab Facility name	Rehab Provider address
Rehab Facility telephone ( )	Rehab Provider fax ( )

#### Member information

Last name	First name	MI	Missouri Care member ID number
Parent/Caregiver responsible for member < 18 years of age			

#### Other insurance information

Other insurance carrier	Policyholder's name	Policy number
-------------------------	---------------------	---------------

#### Therapy Requested

Please indicate the type, frequency, duration, and length of visit per day for therapy requested			
Type	Frequency per week	Estimated duration	Length of visit per day
Physical Therapy	_____	_____	_____
Occupational Therapy	_____	_____	_____
Speech Therapy	_____	_____	_____

## Requested services

Location of service delivery:       home    outpatient hospital    physician's office    rehabilitation center  
 therapist's office    other (specify) \_\_\_\_\_

Date of initial evaluation

Is this work related/or related to a MVA?                               yes       no

Does the member participate in:       First Steps       Early Childhood Program       IEP       IFSP

Is the member currently using orthotics, prosthetics, ambulatory assists (DME, wheelchair, etc) ?       yes       no

If yes, what DME is member using?

Who will be responsible for the home exercise program?

Has the member been compliant with the home exercise program to date?       yes       no       do not know

## Other Health-related services currently provided to the member

Service	Frequency	Provided by
<input type="checkbox"/> Early intervention services	_____	_____
<input type="checkbox"/> Home health aide	_____	_____
<input type="checkbox"/> Hospice	_____	_____
<input type="checkbox"/> Skilled Nursing Services	_____	_____
<input type="checkbox"/> Occupational therapy	_____	_____
<input type="checkbox"/> Personal care attendant	_____	_____
<input type="checkbox"/> Physical therapy	_____	_____
<input type="checkbox"/> Speech/language therapy	_____	_____
<input type="checkbox"/> Other: _____ (specify)	_____	_____

## Medical Necessity

Provide a brief summary of medical necessity for the therapy treatment you are proposing.

What are the objective measures you have used, or plan to use, to chart progress towards the stated goals?

Please record attendance to date: scheduled/attended cancelled/no show.

**If ongoing therapy is requested, submission of the last four visit's progress notes should accompany a written request along with updated treatment plan and goals with anticipated new length of proposed treatment**

\_\_\_\_\_  
Rehab Therapist's name and title

\_\_\_\_\_  
Therapist's signature

\_\_\_\_\_  
Date

## Medical Necessity Therapy Services

Medically necessary **physical therapy services** must be restorative or for the purpose of designing and teaching maintenance program for the patient to carry out at home. The services must also relate to a written treatment plan and be of a level of complexity that requires the judgment, knowledge and skills of a physical therapist (or a medical doctor/doctor of osteopathy) to perform and/or supervise the services. The amount, frequency and duration of the physical therapy services must be reasonable; the services must be considered appropriate and needed for the treatment of the disabling condition and must not be palliative in nature.

**Occupational therapy services** are considered medically necessary only if there is a reasonable expectation that occupational therapy will achieve measurable improvement in the member's condition in a reasonable and predictable period of time. Occupational therapy is medically necessary in selected cases when this care is prescribed by a physician, and either of the following criteria applies:

- To provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, or injury; *or*
- To learn or relearn daily living skills (e.g., dressing, eating and bathing) or compensatory techniques to improve the level of independence in the activities of daily living.

**Speech therapy services** are medically necessary for non-chronic conditions and acute illnesses and injuries, subject to applicable terms and limitations. Services rendered for the treatment of delays in speech development (unless resulting from disease, injury or congenital defects) are commonly excluded. Speech therapy is covered for the following indications:

1. To restore or improve speech in members who have speech-language disorders that are the result of a non-chronic disease or acute injury; *or*
2. The member has a speech delay that is associated with a specifically diagnosable disease, injury, or congenital defect (e.g., cleft palate, cleft lip, etc.).