Therapy Cover Sheet Form

Nursing Home and Outpatient Therapy Only

Please send via secure email to therapyrequests@inclusa.org or fax to 866-672-6648

Provider Name: _____

Contact Name: _____

Phone: _____ Fax: _____

Member Name: _____ DOB: _____

Payer: Primary: ☐ MC ☐ FC ☐ Other: _____

Secondary: ☐ MC ☐ FC ☐ Other: _____

Discipline*	Frequency	Start Date	End Date
PT Evaluation			
PT Visits			
Note:			
OT Evaluation			
OT Visits			
Note:			
ST Evaluation			
ST Visits			
Note:			
MH/AODA Assessment			
MH/AODA Sessions			
Note:			
* **A plan of care for each discipline must be faxed at time of request for services.**			

Prior authorization of evaluation and first treatment if occurring on the same day is waived if the plan of care for each discipline is submitted with this completed form. IDT staff will confirm authorization for evaluation and treatment within 24 hours via Inclusa's referral process.

Request for ongoing therapy as identified above will follow Inclusa's customary authorization process. Provider will receive confirmation of authorization via Inclusa's referral process however there is no need to bill against the authorization until Medicare coverage ends for these services. Provider will receive phone notification if ongoing treatment is declined by the member or denied by the Inclusa Care Team.

For assistance contact 1-888-544-9353 option 6 or ACS-Residential-CSL-NH-Therapy@inclusa.org.