

Revised: 2/1/2023

Therapy Referral Review by Ordering Physician Attestation Form

Patient Information:

Name:	DOB:	Medicaid ID#:
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Referring/Requesting Physician:

Name:	Phone:
NPI #:	Fax:

Therapy Service Provider:

Name:	Phone:
NPI #:	Fax:

Discipline: (Circle)

Physical Therapy

Occupational Therapy

Speech Therapy

Services Requested:

CPT Codes	Modifiers	CPT Codes	Modifiers

Start Date:	End Date:	Number of Sessions:	Duration (PT/OT Only):	Total Units/Visits Requested:
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I attest that the referring physician agrees with the proposed plan of care (CPT codes, dates, frequency and duration). The referring physician has been provided a copy of the most recent evaluation/re-evaluation/progress summary and plan of care.

Signature

Date

Position