Driscoll Health Plan

URAC ACCREDITED Health Plan Expires 05/01/2023

Therapy Referral Review by Ordering Physician Attestation Form

Patient Information:

Name:	DOB:	Medicaid ID#:

Referring/Requesting Physician:

Name:	Phone:	NPI #:

Therapy Service Provider:

Name:	Phone:	NPI #:

Discipline: (Circle)

Physical Therapy Occupational Therapy Speech Therapy

Services Requested (CPT Codes):

Start Date:	End Date:	Number of Sessions:	Duration (PT/OT Only):	Total Units/Visits Requested:

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