**Therapy Referral Review by Ordering Physician Attestation Form**

Patient Information:

|  |  |  |
| --- | --- | --- |
| Name: | DOB: | Medicaid ID#: |

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 |
|  |  |  |  |
|  |  |  |  |
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| --- | --- | --- | --- | --- |
| 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.

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Signature Date

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Position