

# Network Health Plan/Network Health Insurance Corporation Therapy Authorization Request Form

**Fax Request** *Commercial Care Management Dept: 920-720-1903*  
*Medicare Care Management Dept: 920-720-1916*

**Telephone:** *Commercial Care Management Dept: 920-720-1600*  
*Medicare Care Management Dept: 920-720-1602*

**\*Form Completed by:**

**\*Date Form Completed:**

If this is a request to extend services, please enter the original authorization number:

MEMBER INFORMATION	ORDERING PROVIDER INFORMATION	RENDERING PROVIDER INFORMATION
*Member/Patient Name:	*Ordering Provider:	*Rendering Provider & Facility:
*DOB:	Phone #:	Phone #:
Member ID #:	Fax #:	*Fax #:
*Diagnosis: ICD-9:		NPI #:

	Type of Therapy (PT, ST or OT)	Beginning Date of Service	Ending Date of Service	Number of Visits (Visits per Therapy Grid if initial request) (If extension request, please provide supporting therapy notes)	Comments
1	_____				
2	_____				
3	_____				
4	_____				
5	_____				
6	_____				
7	_____				
8	_____				

**\* Required Fields**

If you have questions about benefits, please call Customer Service at 1-800-826-0940 or 920-720-1300 for NHP Commercial members and 1-800-378-5234 or (920) 720-1345 for Medicare Advantage members. If there is insufficient information, the form will be returned.

<b>NHP Only</b>	Authorization #:	# Units Approved
Care Management Coordinator: _____	Date Received: _____	Start Date: _____ End Date: _____