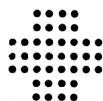


Fax Request Form

62266

To: OrthoNet Fax #: (866) 800-7485

Fax Date: _____ # of Pages Faxed: _____



OrthoNet



Instructions:

1. Use this form as a Fax Cover Sheet and send all supporting clinical data with this request
2. Please ensure that this form is a DIRECT COPY from the MASTER
3. Please PRINT, in black ink, one character per box for ALL requested information
4. Please completely fill in each circle that represents the corresponding NUMBER entry
5. For assistance in completing this form, please call OrthoNet Provider Services at (800) 448-6152

For Internal Office Use Only

A S P

THERAPY PROVIDER INFORMATION

Facility Name

Or

Provider First Name

Provider Last Name

Street Address

City

State

Zip

Telephone Number

Return Fax Number

Facility/ Provider ID Number

Provider Tax ID Number

National Provider Identifier (NPI)

Facility Tax ID Number

Facility NPI Number

Individual Tax ID Number

Individual NPI Number

PATIENT INFORMATION:

First Name

Last Name

Date of Birth

Month

Day

Year

Alpha Prefix

Member ID Number

Diagnosis Code (ICD-9 or ICD-10 Format)

REQUEST INFORMATION:

Request for:

Therapy Visits Precertification

Other Procedure: _____

Service Type:

Physical Therapy

Occupational Therapy

Is this request for post-operative therapy visits?

Yes No

Initial Evaluation Date

Month

Day

Year

