American Therapy Administrators of Florida

Patient Intake Form

Select plan and fax to the corresponding number

For inquiries or status of pending requests, call:	☐ **Sunshine**	☐ **AmeriGroup** ☐ **Humana**
1 (888) 550-8800 x1	Fax: 1 (800) 980-2380	Fax: 1 (855) 410-0121

☐ **Routine** ☐ **Urgent**

Facility / Group Name			TIN Number
Facility / Group Address (where services will be rendered)			Facility / Group NPI
City		State	Zip
Contact Person	Phone		Fax
Treating Therapist Name (rendering)			Treating Therapist NPI
Referring Provider Name			Referring Provider NPI
Patient Last Name	Patient First Name		Patient ID
Patient County			Patient Date of Birth (mm/dd/yyyy):

Line of Business ☐ **Medicare** ☐ **Medicaid** ☐ **Medicaid Healthy Kids**

Place of Service ☐ **Office (11)** ☐ **Independent Clinic (49)** ☐ **Other [_ _]**

Primary Diagnosis Description

☐ **ICD-9** ☐ **ICD-10**	ICD Code 1	ICD Code 2	ICD Code 3	ICD Code 4

If Status Post Surgery, List Procedure

Date of Surgery (mm/dd/yyyy)	For Cerebral Vascular Accident (CVA), list Date of CVA (mm/dd/yyyy):

☐ Please check box to confirm Member's Plan of Care has been submitted and approved by ordering Provider and the frequency and duration are: _____ times/ per week _____ number of weeks	☐ Please check box to confirm Ordering Provider will be notified when therapy has been completed and whether the goals have been achieved (Member discharged) or Therapy was stopped	☐ Please check box to confirm The servicing provider has reviewed the approved Plan of Care with the Enrollee including the frequency and duration, and will provide these services.

STEP 1: FILL OUT SEPARATE PATIENT INTAKE FORM FOR EACH DISCIPLINE

☐ **Physical Therapy** ☐ **Occupational Therapy** ☐ **Speech Therapy** Evaluation Date (mm/dd/yyyy):

TEST SCORE	Test Used	Test Results (Standard Deviation)	Test Result (Age Equivalency) ____ ____ ☐ Month ☐ Year

Note/Comments:

STEP 2: FOR EXTENDED EPISODE FEE (EEF) REQUESTS (After completion of Step 1 above, if patient needs continued therapy, complete below and fax to ATA-FL)

Since evaluation date: # visits scheduled:	Number of Visits Attended:	Date of Last Visit (mm/dd/yyyy):

STEP 3: APPLICABLE IF PATIENT IS IN CONTINUOUS THERAPY FOR 4 MONTHS (You may request an additional EEF Level by submitting the following information 4 months after eval date)

Since evaluation date: # visits scheduled:	Number of Visits Attended:	Date of Last Visit (mm/dd/yyyy):

Additional Information: