1199SEIU
Benefit and Pension Funds
National Benefit Fund • Health Care Employees Pension Fund
Greater New York Benefit Fund • Greater New York Pension Fund
Home Care Employees Benefit and Pension Funds • Home Health Aide Benefit Fund
330 WEST 42ND STREET | NEW YORK, NY 10036-6977 | WWW.1199SEIUBENEFITS.ORG

Care Management Programs Department
PT, OT & ST* Request Form
For Benefit Extensions beyond 25 visits/calendar year

Fax completed form to (646) 473-7447. Include Initial/Re-evaluation report inclusive of initial and current progress notes.

♦♦

1199SEIU Member's Name: ____

Member ID | | | | | | | | | | |

Patient (if not member): ______________________________ Patient date of birth: __________ Age: _____

♦♦

Request submitted by: ____Date: ______ / ______ / _______
Physician Name: ____ Date: ______ / ______ / _______
Physician Specialty: __________________________________ Telephone: (_________) _________ - __________
TIN # (Tax ID): ______________________________________ MD Fax #: (_________) ___________ - _________
Office Address:
____

Name of Facility/Vendor Providing Service:
____

TIN # (Tax ID #): ________________________________ Vendor Fax Number: (_________) __________ - __________
Address:____
Vendor Authorized Signature: ____________________Print Name: ______________Title:___________________________
Contact Person: ____________________________________ Title: ______________________________________
Telephone: (_________) _________ - _________

♦♦

Service Type: ☐ PT ☐ OT ☐ ST

Total # of therapy visits rendered to date for current calendar year: _________ Additional visits requested: ________________

Is Patient's Condition Related To:

Employment? (Current or Previous)	☐ No	☐ Yes
Auto Accident?	☐ No	☐ Yes if yes, date _________________
Other Accident?	☐ No	☐ Yes if yes, date & type of accident_____________________

Is legal action being taken? ☐ No ☐ Yes
Is There Other Insurance? ☐ No ☐ Yes If yes, List_____________________________

Member ID: | | | | | | | | | | | Patient's Name: ____________________________________

Reason for continuing treatment:

____

____

Is this request relating to post-surgical care? ☐ No ☐ Yes If yes, date & type of surgery: ______________________________

____

ICD-9 Code(s) & Description:

Principal:____

Secondary:____

Fax Initial / Re-evaluation report and up-to-date progress notes along with this completed form to support the following:

Functional Level:

____

____

Assessment of change in patient condition since last visit:

____

____

Treatment Plan:

____

____

List quantifiable & attainable treatment goals: ____

Expected outcome: ____

____

Range of Motion Values: ____

Muscle Strength: 0, -1, 1, 1+, -2, 2, 2+, -3, 3, 3+, -4, 4, 4+, -5, 5

❒ Trace ❒ Poor ❒ Fair ❒ Good ❒ Normal

♦♦

Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST.

In order to process your request, the Provider TIN & Fax #'s along with the CPT/HCPS & ICD-9 codes must be included.

Complete this form and attach copies of pertinent medical documentation or copies of the physician's actual office chart to support your request. Fax completed form to (646) 473-7447.

The Fund's Pre-Authorization Call Center is available Monday to Friday, 9:00 AM to 5:00PM at (646) 473-7446.

Pre-authorization requirements are regularly updated and are therefore subject to change; periodically visit the website at www.1199SEIUBenefits.org for our most recent pre-authorization requirements, authorization request forms and other pertinent information located in the "For Providers" section.

***Physical therapy, occupational therapy, speech/language pathology services.**