	THEM Therap	y Fax Request Form
43733 PLEA	SE USE THIS FORM FO	R ALL NH & CT ANTHEM MEMBERS
Fax Date:# of Pages Faxed: Please fax to OrthoNet at: 1-888-788-0809		
THERAPY PROVIDER INFORMATION		
Facility or Provider Name		
Street Address		
		State ZIP
Telephone Number		FAX Number
		(
		* The above fax number will be used to confirm your address/ location if we are unable to contact you using the fax number on file with Anthem.
National Provider I dentifier (NPI)		ANTHEM Provider ID Number
O Individual NPI Number O Facility NPI Number		
PATI ENT INFORMATION		REQUEST INFORMATION
First Name		Request for:
		O Therapy Visits Precertification
Last Name		O Other Procedure:
		Service Type:
		O Physical Therapy O Occupational Therapy O Splint
Date of Birth		Is this request for post-operative therapy visits?
		O Yes O No
		Initial Evaluation Date
ANTHEM Member ID Number		
		Month Day Year
		Diagnosis Code (i.e. 8430 or V4365)
		Management Service:
		O Utilization Management O Consultative Management
Instructions:		
 Use this form as a Fax Cover Sheet and send all supporting clinical data with this request. 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 and For Internal Office Use Only		
 completely fill in each circle that represents the corresponding NUMBER entry where applicable. 4. For assistance in completing this form, please call OrthoNet provider services toll free at 1-888-788-0807. 		
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