Request for Initial Outpatient Therapy (Form TP-1)

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CCP - Texas Medicaid & Healthcare Partnership PO Box 200735 Austin TX 78720-0735 1-800-846-7470 CCP FAX: 1-512-514-4212	Texas Medicaid & Healthcare Partnership CSHCN PO Box 200855 Austin TX 78720-0855 1-800-568-2413 or 1-512-514-3000 FAX: 1-512-514-4222

Medicaid Number:		CSHCN Number:	
Client Name:	Date of birth: / /	Telephone:	
Client Address:			
Has the child received therapy in the last year from the public school system? ☐ Yes ☐ No			
Date of Initial Evaluation	PT	OT	SLP

A copy of the initial evaluation must be attached

ICD-9 Code/Diagnosis:	Date of onset:

Category of Therapy Being Requested

PT/OT for:	☐ Developmental anomalies	☐ Pre-surgery	☐ Post-surgery Date of surgery / /	
☐ Cast Removal Date Removed / /		☐ Serial Casting	☐ Acute Episode of Chronic Condition	
☐ New Condition	☐ Specialty Clinic	☐ Home Program	☐ ADL (activities of daily living)	
☐ Equipment Assessment		☐ Equipment Training		
Speech for:	☐ Craniofacial	☐ Developmental Anomalies	☐ New Condition	☐ Post Cochlear Implant

Check the service requested, indicate the date(s) of service and frequency per week or month:
Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.

Service Type	Service Date(s)		Frequency per week	Frequency per month
	From:	To:		
☐ **PT**	/ /	/ /		
☐ **OT**	/ /	/ /		
☐ **SLP**	/ /	/ /		

Procedure code(s) for therapy services:

Specialist	Name	Signature	Date Signed
Physician			/ /
PT Therapist			/ /
OT Therapist			/ /
SLP Therapist			/ /

Provider Information

Name:	Telephone:	Fax:
Address:		

Medicaid Identifying Information

TPI:	NPI:	Taxonomy:	Benefit Code:

CSHCN Identifying Information

TPI:	NPI:	Taxonomy:	Benefit Code:

FOR OFFICE USE ONLY: Medicaid ☐ Yes ☐ No HMO ☐ Yes ☐ No Restrictions:

PAN# Valid To

FORM TP-1

Effective Date_07302007/Revised Date_06012007