53525

HUMANA Therapy Fax Request Form

PLEASE USE THIS FORM FOR ALL HUMANA MEMBERS

Fax Date: _____# of Pages Faxed: _____ Please fax to OrthoNet at: 1-800-863-4061

THERAPY PROVIDER INFORMATION

Facility Name

Street Address

City State ZIP

Telephone Number ( ) -

Fax Number ( ) -

Provider Tax ID Number

National Provider Identifier (NPI)

○ **Facility Tax ID Number**

○ **Individual Tax ID Number**

○ **Facility NPI Number**

○ **Individual NPI Number**

PATIENT INFORMATION:

First Name Last Name Date of Birth

Month / Day / Year

HUMANA Member ID Number Diagnosis Code (ICD-10 Format)

REQUEST INFORMATION:

Request for:

○ Onset (Commencement) of Therapy Services

○ Extension of Therapy Services

○ Other Procedure: _____

Service Type:

○ Physical Therapy

○ Occupational Therapy

○ Speech Therapy

Is this request for post-operative therapy visits?

○ Yes ○ No

If this is a HUMANA Medicare Advantage PFFS member, is this request for an Advanced Coverage Determination (ACD)? ○ Yes ○ No

Initial Evaluation Date

Month / Day / Year

Instructions: 1. Use this form when requesting prior authorization of therapy services for Humana members.

2. **Please complete and Fax this request form along with all supporting clinical documentation to OrthoNet at 1-800-863-4061.** (This completed form should be page 1 of the Fax.)
3. Please PRINT, in black ink, one character per box for ALL requested information and completely fill in each circle for selection where applicable.
4. For assistance in completing this form, please call OrthoNet provider services toll free at 1-800-862-4006.

NOTE: The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material/information in error, please contact the sender and delete or destroy the material/information.

Reset

For Internal Office Use Only

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