home state health™

SUBMIT TO
Home State Health STRS
Utilization Management Department
16090 Swingley Ridge Road, Suite 500
Chesterfield, MO 63017
PHONE 1.855.694.4663 FAX 1.855.847.1011

OUTPATIENT TREATMENT REQUEST (OTR)/SPECIALTY THERAPY & REHAB SERVICES

Please write clearly and only in designated areas. Authorization cannot be provided unless ALL requested information is included.

REQUIRED DOCUMENTATION CHECKLIST

- ☐ **CURRENT PLAN OF CARE:** Signed and dated specifying frequency, duration and type of treatment.
- ☐ **CURRENT ASSESSMENT:** Must include measurable objectives (ROM/Strength/Pain, etc.), an evaluation that includes standardized functional assessment results for developmental delay requests, if appropriate, and therapist's observations.
- ☐ **CONTINUATION OF CARE REQUESTS:** Documentation of specific progress toward previous goals and updated/current plan of care.
- ☐ **PRESCRIPTION FOR THERAPY:** Must be signed and dated by physician. Outpatient prescriptions are good for 1 year, EPSDT prescriptions are good for 6 months and Home Health prescriptions are good for 60 days unless limited by the referring provider. Verbal orders, for home health requests only, are valid for 30 days from date of issue.

Initial Evaluation does not require authorization.

MEMBER INFORMATION

Member ID# ______________________________

Date of Birth ______________________________

First Name ______________________________

Last Name ______________________________

Address/City/State/Zip Code ____________________

____

Phone ______________________________

Does the member have additional health insurance?

If Yes, please provide: ______________________________

DIAGNOSIS/DISORDER

Please indicate ICD-10 code(s)

Primary Diagnosis: ______________________________

Secondary Diagnosis: ______________________________

Treatment Area/Focus: ______________________________

EARLY SUPPORTS AND SERVICES (ESS)

Is the member receiving services through First Steps?

☐ Yes ☐ No

Is the member receiving services through his/her school's Individualized Education Program (IEP)? ☐ Yes ☐ No

If YES, please submit the most recent copy of the member's IEP/IFSP with this request.

PROVIDER PERFORMING THE SERVICES

Check GROUP or INDIVIDUAL to indicate how to authorize.

☐ Group ☐ Individual

Group/Facility Name ______________________________

Individual Rendering Provider Name ____________________

____

Address/City/State/Zip Code ____________________

____

____

Provider Phone ______________________________

Provider Fax ______________________________

Group/Facility/NPI (required) ____________________

Rendering Provider NPI (required) ____________________

Tax ID (required) ______________________________

Contact Name ______________________________

Contact Phone ______________________________

PRESCRIBING PROVIDER

Prescribing Provider Name ____________________

Phone ______________________________

Fax ______________________________

THERAPY SERVICE AUTHORIZATION REQUESTS FOR TREATMENT

Service Location: ☐ Hospital-Outpatient ☐ Clinic/Rehab Center ☐ Office ☐ Home

Service	Date Treatment Initially Started	Frequency (visits seen per month or week)	Total Visits or Units Requested	Requested Start Date for Treatment ☐ use receipt date of this request	Requested End Date for Treatment ☐ use end date of the written Plan of Care	% of delay at last evaluation
Speech Therapy		____ x ☐ week or ☐ month				
Physical Therapy		____ x ☐ week or ☐ month				
Occupational Therapy		____ x ☐ week or ☐ month				

☐ **URGENT REQUEST** - By checking this box, I certify that this is an urgent request for medically necessary treatment, which must be treated within 24 hours.

____

Signature of Prescribing Provider (ex: MD, APRN, etc.) **(Required)**

If not signed by a Prescribing Provider (ex: MD, APRN, etc.), request will be processed according to standard turn around time.

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Home State Health requires Prior Authorization before Therapy Services are rendered. Please refer to our website, www.homestatehealth.com, for the most current listing of authorized procedures and services. Please note that an authorization is not a guarantee of payment, and is subject to utilization management review, covered benefits, and members/provider eligibility.