



home state health™

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

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

Please write clearly and only in designated areas. All required fields MUST be filled in, incomplete forms will be rejected. Copies of ALL supporting clinical information are required. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION OR A DENIAL.

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 if performed by a participating provider. All Services performed by non-participating providers require prior 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 <input type="checkbox"/> use receipt date of this request	Requested End Date for Treatment <input type="checkbox"/> use end date of the written Plan of Care	% of delay at last evaluation
Speech Therapy		<input type="checkbox"/> ___ x week or <input type="checkbox"/> month				
Physical Therapy		<input type="checkbox"/> ___ x week or <input type="checkbox"/> month				
Occupational Therapy		<input type="checkbox"/> ___ x week or <input type="checkbox"/> 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.