



VSHP
Volunteer State Health Plan
1 Cameron Hill Circle
Chattanooga, TN 37402
vshptn.com



This Information is:
 Public Internal (**Volunteer State Health Plan Use Only**) Confidential Highly Confidential

Therapy Request Form
Physical/Speech/Occupational
Request Form

BlueCare/TennCareSelect
Fax Number: 1-800-292-5311

BlueCare <input type="checkbox"/>	TennCareSelect <input type="checkbox"/>
-----------------------------------	---

****Prior Authorization is not required for children under the age of 21**
****Prior Authorization is not required for the initial visit for evaluation of member's therapy needs**

Member Information

Member Name: **Member ID Number:**
Address:

Date of Birth: **Member Phone Number:**

Diagnosis: (List all)

Therapy Provider Information

Ordering Physician: **Provider Number:**

National Provider Identifier: **Tennessee Medicaid Number:**

Phone Number: **Fax Number:**

Contact:

Servicing Provider: **Provider Number:**

National Provider Identifier: **Tennessee Medicaid Number:**

Phone Number: **Fax Number:**

Contact:

*A copy of the MD's written order (or details of the verbal order) must be submitted with this fax request.



Date of Evaluation:

Therapy Being Requested:

Pain Rating: **Date of Pain Rating:**

Pain Location:

Conservative TX used and/or failed:

Date of previous treatment:

Date of last actual MD assessment/follow up:

If this is post-operative therapy, what procedure:

Date of procedure:

If prior therapy, is there an HEP currently in place:

Is the patient compliant with HEP:

Problems:

- 1.
- 2.
- 3.
- 4.

Assistive Devices:

Rehab Potential:

Short Term Goals: (initial requests)

- 1.
- 2.
- 3.
- 4.

Target completion date

Long Term Goals: (initial requests)

- 1.
- 2.
- 3.
- 4.

Target completion date:

If therapy continuation, document the following: goals, progressing or not progressing, met:

ROM/strength/functional limitations:

Date of the assessment:

Notification is not a confirmation of coverage or benefits. Benefits remain subject to all contract terms, benefit limitations, conditions, exclusions, and the patient's eligibility at the time services are rendered. This request may be subject to retrospective review based on Medical Policy.

This facsimile contains privileged and confidential information intended only for the use of the specific individual or entity named above. If you or your employer are not the intended recipient of this facsimile (or an agent responsible for delivering it to the intended recipient), you are hereby notified that, any unauthorized distribution or copying of this facsimile for the information contained in it, is strictly prohibited. If you have received this facsimile in error, please immediately notify the person named above by telephone and return the original facsimile to the above address via the U.S. Postal Service. Thank You.