SOUND HEALTH & WELLNESS TRUST
REHABILITATION/THERAPY PRE-AUTHORIZATION REQUEST FORM

TO: SOUND HEALTH & WELLNESS TRUST PRE-AUTHORIZATIONS **FAX # 206-285-4437**

THERAPY PROVIDER NAME:_____ **PH#:** _____

ADDRESS: _____ **FAX#:** _____

PLEASE TYPE OR PRINT LEGIBLY

Date _____

Ordering Physician: _____ Physician Phone: _____

Member Name: _____ Member SS/ID #: _____

Patient Name: _____Patient Date of Birth: _____

Type of Therapy requested, circle one/all that apply:

Physical Therapy Occupational Therapy Speech Therapy Massage Therapy Cardiac/Pulmonary Therapy

Documentation Required for Review of Preauthorization Request:

✧ **INITIAL THERAPY:** **Begin date for this request:** _____

Submit initial physician referral and initial evaluation from physician and therapist
If accident related, how, when & where occurred _____

Work related Y_____N_____ DOI _____ Motor vehicle related Y_____N_____ DOI_____

✧ **CONTINUED THERAPY:** **Begin date for this request:** _____

Follow-up notes & brief letter of medical necessity from referring physician.
Flow sheets showing all visits from start of care through current from therapist
Current progress reports signed and dated by referring physician or current referral

Diagnosis/ICD-10 Codes provided by referring physician: _____

Therapy procedure codes/CPT _____

Date of Initial Evaluation: _____ Total # visits from initial evaluation to current _____

Frequency of Visits: _____ Duration of Treatment (in weeks): _____

Treatment Plan with goals: _____

_____

_____

Prognosis: _____

Estimated Date of Discharge: _____

Referring Physician/Provider Signature:_____ **Date:** _____