HEALTH CARE AUTHORITY

TITLE XIX REQUEST FOR PRIOR APPROVAL
INPATIENT REHABILITATION SERVICES

MAIL TO:
Third Party Assessor (TPA)

Patient's Name	Medicaid Number	Date of Birth	Sex ☐ M ☐ F
Diagnosis		Name/Address/Zip Code of Facility to which Admission is Requested	
Provider Number	NPI Number	Taxonomy Number	Date of Onset of Disability (if known)
Has this patient been treated at this facility before? ☐ Yes ☐ No		Name of Referring Physician	

ASSESSMENT OF PATIENT'S DISABILITIES

DESCRIPTION OF COMPREHENSIVE REHABILITATION PLAN

GOALS OF THERAPY

Number of Days of Inpatient Rehabilitation Request_____	Request for Evaluation ONLY ☐	Physician Signature
☐ Approved for_____ days PA Number _____	Beginning Date _____ Ending Date _____	☐ Request Denied PA Number _____

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Distribute to: UR Agent
Fiscal Agent
Provider File