Request for Initial Outpatient Therapy (Form TP-1)

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RightCare
SCOTT & WHITE HEALTH PLAN
The one Texans trust.

RightCare Medical Management
1-855-691-SWHP (7947)
FAX: (512) 383-8703

Medicaid Number:		CSHCN Number:
Client Name:	Date of birth: / /	Telephone:
Client Address:		

Has the child received therapy in the last year from the public school system? ☐ Yes ☐ No

Date of Initial Evaluation	PT	OT	SLP

A copy of the initial evaluation must be attached

ICD-9 Code/Diagnosis:	Date of onset:

Category of Therapy Being Requested

PT/OT for: ☐ Developmental anomalies ☐ Pre-surgery ☐ Post-surgery Date of surgery / /

☐ Cast Removal Date Removed / / ☐ Serial Casting ☐ Acute Episode of Chronic Condition

☐ New Condition ☐ Specialty Clinic ☐ Home Program ☐ ADL (activities of daily living)

☐ Equipment Assessment ☐ Equipment Training

Speech for: ☐ Craniofacial ☐ Developmental Anomalies ☐ New Condition ☐ Post Cochlear Implant

Check the service requested, indicate the date(s) of service and frequency per week or month:
Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.

Service Type	Service Date(s)		Frequency per week	Frequency per month
	From:	To:		
☐ **PT**	/ /	/ /		
☐ **OT**	/ /	/ /		
☐ **SLP**	/ /	/ /		

Procedure code(s) for therapy services:

Specialist	Name	Signature	Date Signed
Physician			/ /
PT Therapist			/ /
OT Therapist			/ /
SLP Therapist			/ /

Provider Information

Name:	Telephone:	Fax:
Address:		

Medicaid Identifying Information

TPI:	NPI:	Taxonomy:	Benefit Code:

CSHCN Identifying Information

TPI:	NPI:	Taxonomy:	Benefit Code:

FOR OFFICE USE ONLY: Medicaid ☐ Yes ☐ No HMO ☐ Yes ☐ No Restrictions:

PAN# Valid To