SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711
Fax: 715.221.6616

Concurrent Outpatient Therapy Treatment

Prior Authorization Request

Date _____

Member information		
Member name (print)	MHN	Date of birth (month/day/year)

Provider information		
Provider name (print)	NPI number	Telephone number
Provider address		Fax number
Facility name		

Treatment information			
Date of onset (month/day/year)	Date of initial treatment (month/day/year)	ICD code(s)	CPT code(s)

Requested services:

☐ Habilitative ☐ Rehabilitative

Type of service:

☐ Physical therapy ☐ Occupational therapy ☐ Speech therapy ☐ Athletic trainer

Describe services provided

Justification

- Services must be provided by a licensed therapist or athletic trainer (if allowed by member's plan)
- Services provided must be considered reasonable and necessary as per the member's certificate of coverage.
- There must be a reasonable expectation that the member's condition will improve with in a generally predicted time frame.

Services Requested	Expected Frequency	Expected Number of Visits	Expected End Date	Total Number of Visits Completed to Date/ Including Date of Last Visit
☐ Physical therapy				
☐ Occupational therapy				
☐ Speech therapy				
☐ Athletic trainer				

Supporting documentation required

In addition to this completed form, the following documentation must be provided in order to provide a coverage decision: a) Re-evaluation (if applicable); b) Progress notes (daily and required updates); c) Treatment notes/logs; d) Plan of care; e) Goals/Objectives/Prognosis and rationale for additional care

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:	Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715.221.6616	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Customer Service at 1.800.472.2363.

