THE HSC HEALTH CARE SYSTEM
Health Services for Children with Special Needs, Inc.

HSCSN Request for Rehabilitative Therapy

This form must be completed by a treating practitioner. Fax this form and supporting documents to HSCSN Utilization Management at **Fax: 202-721-7190** or email: UM@hschealth.org. **Medical records documenting the most recent face-to-face visit should be submitted with each request.**

IMPORTANT TO NOTE: This request will not be processed unless all of the items below are completed.

DATE OF ORDER:		
PROVIDER	**ENROLLEE**	
Ordering Provider (MD or NP):	**Enrollee Name:**	
Provider NPI #:	**Enrollee ID:**	**DOB:**
Provider Phone #: Fax #:	**Primary Diagnosis:** (Include ICD-10 code)	
Provider Email:	**Other Diagnoses:**	

OUTPATIENT vs HOME-BASED THERAPIES
Routine therapies are provided in an outpatient setting. Home-based therapies have limited availability. Home-based therapies may be appropriate if the enrollee has difficulty getting in and out of the home or if the therapy addresses activities that are done in the home. Initial authorization of therapy and appropriate setting will be for evaluation and up to 10 visits. Subsequent authorization is requested by the therapy provider, up to 1 year for outpatient therapy and up to 60 days for home-based therapy.

SERVICE REQUESTED:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech-Language Therapy ☐ Other Therapy: _____

☐ Outpatient ☐ Home-Based ☐ Outpatient if home-based not available

REASONS FOR REFERRAL:

GOALS OF THERAPY:

ACTIVITIES OF DAILY LIVING (Check the level of assistance needed)

Bathing: I☐ S☐ M☐ D☐ Toileting: I☐ S☐ M☐ D☐

Grooming: I☐ S☐ M☐ D☐ Dressing: I☐ S☐ M☐ D☐

Eating: I☐ S☐ M☐ D☐ Mobility-Ambulation: I☐ S☐ M☐ D☐

Bowel Incontinence: Yes ☐ No ☐ Bladder Incontinence: Yes ☐ No ☐

I=Independent (able to do it on their own)
S=Requires supervision/prompting to minimal assistance
M=moderate dependence (needs moderate physical assistance)
D=dependent (requires maximal to total physical assistance)

Safety Awareness/Judgment
☐ Normal for Age
☐ Mildly Impaired
☐ Moderately Impaired
☐ Severely Impaired

Overall Need for Supervision
☐ Independent (no supervision needed)
☐ Indirect (in home)
☐ Direct (line of sight)
☐ 1:1 Supervision

Signature of Ordering Provider: _____ Date: _____

Printed Name: