Horizon
Horizon NJ Health

In place of this Form you can submit Authorization Requests Online securely via Navinet.
If you are not registered, please visit www.Navinet.net and click *Sign Up* or
call Navinet Customer Care at **1-888-482-8057**

Date of Request: _____

Physical & Occupational Therapy Authorization Request Form

Fax completed form to: Horizon NJ Health **(609)-583-3042**

General Information

Member Name:_____Member ID #:_____DOB:_____

List Any Additional Insurance (company and policy #): _____

_____

Provider Requesting:_____ Provider ID or NPI #:_____TIN#: _____

Facility: _____ Provider ID or NPI #:_____TIN#: _____

Facility Address: _____

Requesting Provider Contact Name: _____ Phone #:_____Fax #:_____

Primary Diagnosis Desc: _____ICD-10 Code(s): _____

Secondary Diagnosis Desc: _____ICD-10 Code(s): _____

Comorbidities/Chronic Diagnoses Desc: _____ICD-10 Code(s): _____

Use this section for Initial Evaluation of services only

Date of Initial Evaluation: _____ ☐ **PT001** ☐ **OT001**

(Note: Authorization will include 5 additional visits)

For Continued Service Requests – provide clinical information and proof of previous visits utilized

PT (PT001)

Total Visits Requested: _____

Total Visits Attended to Date (current episode)**:** _____

Dates of Service (From/To): _____

CPT Codes Requested (list only if not part of PT001 group code)

_____

_____

OT (OT001)

Total Visits Requested: _____

Total Visits Attended to Date (current episode)**:** _____

Dates of Service (From/To): _____

CPT Codes Requested (list only if not part of OT001 group code)

_____

_____

Required Information (please attach treatment plan and any supporting documentation)

Is this request for post-operative therapy visit? ☐ Yes ☐ No Date of Surgery: _____

Is duration of symptoms greater than 90 days? ☐ Yes ☐ No

History of Injury/Surgery: _____

Treatment Plan including frequency & duration: _____

Functional Outcome Measure:

Tool: _____ Score (IE/RE): _____ Score (Current): _____

Functional Outcome Measure (2) if multiple areas are being treated:

Tool: _____ Score (IE/RE): _____ Score (Current): _____

Long Term Functional Goal: _____

Is member enrolled in a medical day program? ☐ Yes ☐ No

If member is pediatric, does member have Individual Educational Plan or Early Intervention Plan? ☐ Yes ☐ No