EmblemHealth®

EmblemHealth Benefit Extensions Treatment Plan

To be completed by the provider rendering therapy. Please print clearly or type, and complete the entire form.

Date of this request: ____ /____ /____	Fax no: 1-212-967-2995	
Patient last name:	Patient first name:	
Date of birth: ____ /____ /____ Sex: ☐ M ☐ F	Policy holder certificate no:	
Insured last name:	Insured first name:	Telephone no:
Name of provider rendering service:		Tax ID no:
Participating provider? ☐ Y ☐ N	Office contact:	Par provider no:
Telephone no: ( )	Fax no: ( )	
Referring physician *(full name)*:		Telephone no: ( )
Referring physician address:		
City:	State:	ZIP code:

Medical History:

Requested service *(select one)*: ☐ PT ☐ OT ☐ ST ☐ MVA-related ☐ WC-Related ☐ Allergy - For allergy treatment, injection treatment start date (month/year): _____/_____		
Date of illness onset: ____ /____ /____		
Positive objective findings and comorbidities:		
Diagnoses (description):	Associated surgery *(for current diagnosis)*:	Date: ____ /____ /____
*ICD code(s): 1. _____ 2. _____ 3. _____		
% improved to date: ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%		
% improved from previous evaluation: _____	% improved from previous functioning before injury/illness: _____	
What is the expectation of maximum medical improvement (MMI) over time?		
Has therapy been continuous? ☐ Y ☐ N	Has patient been instructed in a home exercise program? ☐ Y ☐ N	
Number of visits to reach MMI: _____ From date: ____ /____ /____ To date: ____ /____ /____	Prognosis:	
Start of care (this year):	Visits used to date (this year):	

***Effective October 1, 2014, EmblemHealth will support ICD-10 diagnosis codes.**

Once a total of 32 visits (including base benefit) have been authorized for a particular treatment area, additional extension requests must be accompanied by a prescription from the attending physician with frequency and duration.

Note: The patient must be eligible for coverage at the time the actual services are rendered.

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