Driscoll Health Plan

Revised: 11/1/2024

Therapy Referral Review by Ordering Physician Attestation Form

Patient Information:

Name:	DOB:	Medicaid ID#:

Referring/Requesting Physician:

Name:	Phone:
NPI #:	Fax:

Therapy Service Provider:

Name:	Phone:
NPI #:	Fax:

Discipline: (Circle)

Physical Therapy Occupational Therapy Speech Therapy

Services Requested:

CPT Codes	Modifiers	CPT Codes	Modifiers

Start Date:	End Date:	Number of Sessions:	Duration (PT/OT Only):	Total Units/Visits Requested:

I attest that the referring physician agrees with the proposed plan of care (CPT codes, dates, frequency and duration). The referring physician has been provided a copy of the most recent evaluation/re-evaluation/progress summary and plan of care.

_____ _____

Signature Date

_____

Position