KanCare | sunflower health plan | Cenpatico Improving Lives

SUBMIT TO
STRS Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
PHONE 1.877.644.4623 FAX 1.866.264-4452

OUTPATIENT TREATMENT REQUEST (OTR)/SPECIALTY THERAPY & REHAB SERVICES

Please write clearly and only in designated areas. Authorization cannot be provided unless ALL requested information is included.

REQUIRED DOCUMENTATION CHECKLIST

- ☐ **CURRENT PLAN OF CARE**: Signed and dated specifying frequency, duration and type of treatment.
- ☐ **CURRENT ASSESSMENT**: Must include measurable objectives (ROM/Strength/Pain, etc.), an evaluation that includes standardized functional assessment results for developmental delay requests, if appropriate, and therapist's observations.
- ☐ **CONTINUATION OF CARE REQUESTS**: Documentation of specific progress toward previous goals and updated/current plan of care.
- ☐ **PRESCRIPTION FOR THERAPY**: Must be signed and dated by physician. Outpatient prescriptions are good for 1 year, EPSDT prescriptions are good for 6 months and Home Health prescriptions are good for 60 days unless limited by the referring provider. Verbal orders, for home health requests only, are valid for 30 days from date of issue.

MEMBER INFORMATION

Member ID # _____

Date of Birth _____

First Name _____

Last Name _____

Address/City/State/Zip Code _____

_____

Phone: _____

Does the member have other health insurance? If Yes, please provide:

_____

Member being seen under TBI waiver services? ☐ Yes ☐ No

Member being seen under Autism waiver services? ☐ Yes ☐ No

DIAGNOSIS/DISORDER

Please indicate ICD-10 code(s)

Primary Diagnosis:
Secondary Diagnosis:
Treatment Area/Focus:

EARLY SUPPORTS AND SERVICES (ESS)

This section is to address IDEA (Individuals with Disabilities Education Act) Birth to Three Program Services (Part C) being delivered to address developmental delays.

Is this member receiving ESS services? ☐ Yes ☐ No

Is the service being requested an ESS service? ☐ Yes ☐ No
If yes, refer to state guidance for authorization procedures.

PROVIDER PERFORMING THE SERVICE

Check GROUP or INDIVIDUAL to indicate how to authorize.

☐ Group ☐ Individual

Group/Facility Name _____

Individual Rendering Provider Name _____

_____

Address/City/State/Zip Code _____

_____

_____

Provider Phone _____

Provider Fax _____

Group/Facility NPI (required) _____

Rendering Provider NPI (required) _____

Tax ID (required) _____

Contact Name _____

Contact Phone _____

PRESCRIBING PROVIDER

Prescribing Provider Name _____

Phone _____

Fax _____

Have any questions? Call us at 1.877.644.4623
www.cenpatico.com

THERAPY SERVICE AUTHORIZATION REQUESTS FOR TREATMENT

Service Location: ☐ Hospital-Outpatient ☐ Clinic/Rehab Center ☐ Office ☐ Home

Service	Date Treatment Initially Started	Frequency (*visits seen per month or week*)	Total Visits or Units Requested	Requested Start Date for Treatment ☐ use receipt date of this request	Requested End Date for Treatment ☐ use end date of the written Plan of Care
Speech Therapy		_____ x ☐ week or ☐ month			
Physical Therapy		_____ x ☐ week or ☐ month			
Occupational Therapy		_____ x ☐ week or ☐ month			

INITIAL AND RE-EVALUATION REQUESTS

(For PAR providers, one eval and one re-eval are allowed per year without authorization. For Non-PAR providers, all eval requests require prior authorization.)

Did Evaluation and Treatment occur on the same day? ☐ Yes ☐ No

Service Location/Type: ☐ Hospital-Outpatient ☐ Clinic/Rehab Center ☐ Office ☐ Home

Did the member have surgery recently (less than two weeks)? ☐ Yes ☐ No

	Requested Start Date for Initial Evaluation	Discipline
Initial Evaluation Has member had an initial evaluation previously this year? ☐ Yes ☐ No If Yes, why is another initial evaluation warranted?		☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy

	Date of Last Evaluation	Authorization Start Date for Re-evaluation	Discipline
Re-evaluation			☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy

☐ **URGENT REQUEST**- By checking this box, I certify that this is an urgent request for medically necessary treatment, which must be treated within 24 hours.

_____

Signature of Prescribing Provider (ex: MD, APRN, etc.) **(Required)**

If not signed by a Prescribing Provider (ex: MD, APRN, etc.), request will be processed according to standard turn around time.

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Cenpatico requires Prior Authorization before Therapy Services are rendered. Please refer to our website, www.sunflowerhealthplan.com, for the most current listing of authorized procedures and services. Please note that an authorization is not a guarantee of payment, and is subject to utilization management review, covered benefits, and members/provider eligibility.