Instruction for Completion of the HFS 3701T (N-08-14)
Therapy Prior Approval Request Form

All fields are required to be completed unless otherwise noted.

1. **Recipient #** – Enter the nine-digit recipient identification number assigned to the patient for whom the service or item is requested.

2. **Recipient Name** – Enter the name of the patient for whom the service or item is requested.

3. **Birth Date** – Enter the patient's birth date.

4. **Provider Name & Mailing Address**- Enter the provider name and address registered to the provider number provided.

5. **Provider Number**- Enter the HFS Legacy Provider Number as it appears on the Provider Information Sheet.

6. **Provider NPI** – Enter the 10 digit National Provider Identification number of the provider that will provide the requested therapy.

7. **Provider Telephone/Contact Name** – Enter the area code/telephone number and a contact name of someone who can provide information regarding the prior approval if necessary.

8. **Referring Physician Name**– Enter the name of the practitioner who signed the order or prescription recommending that the patient receive a specific therapy.

9. **Diagnosis Code**– Enter the ICD-9-CM (International Classification of Diseases) code, or upon implementation, the ICD-10-CM code that corresponds to the description listed in box #10.

10. **Diagnosis Description**– Enter the written description that corresponds to the diagnosis code listed in box #9.

11. **Procedure Code**– Enter the five-digit CPT code that identifies the specific therapy being requested.

COS- (Category of Service) - Enter one of the following:

- Physical Therapy- COS-11
- Occupational Therapy- COS-12
- Speech Therapy- COS-13

Begin Date/End Date- Enter the dates requested for therapy to begin and end.

Frequency x Duration- Enter the number of visits per week x the number of weeks ordered for the therapy. Example: 2 visits per week x 4 weeks = 8 visits.

Total Quantity of Visits- Enter the actual number of visits requested. **Do not use units**. This number should not exceed the number of visits ordered.

12. **Procedure Code** – Enter any additional ordered therapy code here.

13. **Procedure Code**– Enter any additional ordered therapy code here.

14. **Procedure Code**– Enter any additional ordered therapy code here.

The following documents should be attached to this form:

- Therapy Evaluation/Plan of Care (POC) signed and dated by the therapist.
- Practitioner order/referral for the requested therapy. Must be signed and dated by the practitioner. Orders signed by APN's, PA-C's, FNP's or NP's are acceptable.

Please Note:

- The evaluation visit should not be included in the quantity of visits requested.
- This form does not apply to therapies requested by Home Health Agencies.
- Requests for supplies and medical equipment should not be submitted on this form.
- All requests for supplies and medical equipment must be made on the HFS 1409, Prior Approval Form

Initial requests (with evaluation) and **renewal requests** (with re-evaluation/progress note) may be faxed to **217-524-0099**.

Reviews and **additional information** may be faxed to **217-558-4359**.

Provider Signature/Date– To be signed and dated in ink by the individual who is to provide the requested therapy service.