**Insurance Authorization Information Forms for Therapies:**
**Following is a list of information we need when calling for authorization:**

Name_____Date_____

Homebound___Why_____

Physical Problems_____

Caregiver_____

Situations in the Home (i.e. safety issues)_____

Assistive Device _____Ambulation (Feet) _____ Abd/Adduction for THR____
Flexion for TKR _____# of Steps inside_____outside_____
**Next Drs. Appointment**_____
Balance_____
Strength_____
ROM (degrees) _____
Pain _____

Difficulties with ADL'S (be specific)
_____
_____
_____
Treatment Plan
_____
_____
_____

Goals_____
_____

Planned Start of Care_____

*Do not request more than 2 weeks of service at a time. At which point we will need a re-eval filled out to submit.*

*Therapist submitting eval*_____