



Facility Name:		Tax ID #:
Facility Address:		
Phone:	Fax:	
Treating Therapist Name (Print):		NPI:
Patient Name:	Patient ID:	Date of Birth:
Patient County:	PCP Name:	Health Plan: WellCare
Med. Dx:	ICD-9 Code(s):	
Treatment Dx:	ICD-9 Code(s):	

Other info, if surgery, list procedure:

Date of Surgery:	For Dx: CVA, list date of CVA:
Member's Plan of Care has been submitted to ordering Provider. <input type="checkbox"/> Please check box to confirm.	Ordering Provider will be notified when therapy has been completed (Member discharged), or Therapy was stopped <input type="checkbox"/> Please check box to confirm.

Fill out separate form for each discipline:

<input type="checkbox"/> Physical Therapy	Evaluation Date:
<input type="checkbox"/> Occupational Therapy	Evaluation Date:
<input type="checkbox"/> Speech Therapy	Evaluation Date:

If a child is enrolled in the following programs, please indicate in the space provided and attach the IFSP/IEP as applicable.

<input type="checkbox"/> (BCW) Babies Can't Wait – Please provider IFSP (dated within the last 6 month)
<input type="checkbox"/> (CIS) Children Intervention Services – Please provider IEP (dated within the last 6 month and Provider Prescription)

Deficits found, Test(s) Administered and: 1) Standard Score (preferred), or 2) Age Equivalence, or 3) Performance level

For Transition requests (Members in active Therapy on TN contract start date:

Date of last Evaluation:	# visits completed:	Date of Last visit:
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