Physicians Health Plan
P.O Box 30377
Lansing, MI 48909-7877
Phone 517-364-8560 1-866-203-0618
Fax 517-364-8409

Outpatient Rehabilitation Request Form

All requests must be accompanied by a copy of the physician order/script, initial evaluation*, assessment of progress toward goals, and description of functional deficits
Fax to: 517-364-8409

Member Information

Member Name: ______________________ Date of Birth: ______________________

PHP Member ID Number: ______________________

Treating Facility Information

Facility Name: ______________________ FAX number: ______________________

Street Address: ______________________ City, State: ______________________

Treating Therapist ______________________ Phone Number: ______________________

Ordering/Referring Provider Information

Provider Name: ______________________ Phone Number: ______________________

Street Address: ______________________ City, State: ______________________

FAX Number: ______________________

Treatment/Request Information

Diagnosis/ICD-9 Code: ______________________ Date of Initial Evaluation: ______________________

Visit Type:

_____ PT _____ OT _____ ST _____ Pulmonary Rehab _____ Cardiac Rehab

Number of visits requested: _____ Dates of Service: From __________ to __________

Number of Visits Already Provided for this Diagnosis/Episode: __________

PHP Authorization Number (if this request is an extension of service) ______________________

FOR PHP USE ONLY

Review Determination:
☐ Approved as requested
☐ Approved with changes

Authorization Number: ______________________

_____ PT _____ OT _____ ST _____ Pulmonary Rehab _____ Cardiac Rehab

Number of visits approved: _____ Dates of service: From __________ to __________

PHP Reviewer Name: Date:

*** Initial evaluation only needs to be submitted with the first request**