Outreach Physical & Occupational Therapy & Speech Rehabilitation, PLLC

Personalized In-Home Treatment

Thank You for Your Referral

Please fax with below Marquee Rx below OR your standard Rx **to (917-591-8494)**

Patient Information:

Full Name (as on Insurance ID Card)_____/
Address_____ City_____State____Zip_____
Home Phone #_____ Cell #_____email:_____
Social Security #_____ Date of Birth_____
Family/Friend/Emergency Contact Name_____
Relationship_____Ph #_____ email_____
Home Attendant: Name / Ph#_____/_____ Agency Ph #_____

Rx: by Referring MD/DO/DPM/NP (or attach your standard Rx)**:**

Referrer Name:_____Address: _____/email:_____
Phone/Fax #_____/_____NPI#_____
I certify these services as medically necessary for the patient's plan of care

Referring Provider Signature:_____Date:_____

Rx Therapy:☐ Physical ☐ Occupational ☐Speech ☐ Swallow (Medicare only)
Frequency/Duration: _____x/week for _____weeks

Diagnosis:_____

Medical History and Precautions: _____

Patient Insurance Information:

In Network: ☐ Medicare ☐ United Health Care ☐ VNS Choice ☐ Managed long term care program (inquire)

Out of Network: ☐ Cigna ☐ Aetna ☐ Humana Medicare

Private Pay: ☐PT / ☐OT : ☐ ($140/Session (up to 67 minutes) **☐**$110 for (up to 45 minutes)

SLP: ☐ $110 per session

Above Primary Ins. Member ID #_____

Secondary Ins.: Company Name / Member ID #_____/_____

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Email: info@outreach-rehab.com