

# 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  Managed long term care program (inquire)  
 Cigna  Aetna

**Out of Network:**  Humana Medicare

**Private Pay:**  PT /  OT :  (\$146/Session (up to 67 minutes)  \$116 for (up to 45 minutes)

**SLP:**  \$116 per session

**Above Primary Ins. Member ID #** \_\_\_\_\_

**Secondary Ins.: Company Name / Member ID #** \_\_\_\_\_ / \_\_\_\_\_

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Fax: 917-591-8494

Email: info@outreach-rehab.com