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: (Optional if attaching face sheet)

Full Name(as on Insurance ID Card): Carol Hauser

Address: _____ City: _____ State: NY Zip: 10023

Home Phone: 212-579-0078 Cell#: _____ Email: _____

Social Security#: _____ Date of Birth: 07/23/1928

Emergency Contact: _____ Relationship _____

Phone#: _____ Email: _____

Agency/HHA: _____ Phone#: _____

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

Referrer Name: Dr. Oscar Garfein NPI#: _____

Address: 425 West 59th street NY, NY 10019 Phone/Fax#: _____

Email: _____

I certify these services as medically necessary for the patient's plan of care.

Referring Provider **Signature**: _____ Date:

Rx Therapy: ☑ **Physical(PT)** ☐ **Occupational(OT)** ☐ **Speech(SLP)** ☐ **Swallow(Medicare)**

Frequency/Duration: _____ **x/week for** _____ **Weeks.**

Diagnosis: _____

Medical History & Precautions: Hip and Pelvic FX, gait

Patient Insurance Information:

Primary Insurance#: _____ **Sec. Ins. Name/ #:** _____

In Network:

☐ Medicare ☐ United Health Care ☐ Managed Long Term Care Program

☐ Cigna ☐ Humana Medicare ☐ HealthFirst

☐ Aetna ☐ Horizon BCBS(NJ) ☐ Empire BCBS(NY)

Private Pay: ☐ **PT/** ☐ **OT** $116 for(up to 60 minutes)

☐ **SLP** $116 per Session

OUTREACH
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