# 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 and/or Swallow (Medicare only)**
**Frequency/Duration:** ______________**x/week for** _____________**weeks**

**Diagnosis:**___________________________________________________________________

**Medical History and Precautions:** _______________________________________________

**Patient Insurance Information:**

**In Network:** ☐ **Medicare** ☐ **United Health Care** ☐ **Healthfirst** ☐ **Cigna**
☐ **Aetna** ☐ **Humana Medicare** ☐ **Empire BCBS**
☐ **VNS Choice Medicare**

**Out of Network:** ☐ **Humana Medicare**

**Private Pay:** ☐**PT** ☐**OT** ☐**SLP:** $130 per session

**Above Primary Ins. Member ID #**_______________

**Secondary Ins.: Company Name / Member ID #**______________________/____________________

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