



American Therapy
Administrators
of Florida



Patient Intake Form

Select plan and fax to the corresponding number

For inquiries or status of
pending requests, call:

1 (888) 550-8800 x1

Sunshine

Fax: 1 (800) 980-2380

AmeriGroup
 Humana

Fax: 1 (855) 410-0121

Routine **Urgent**

Facility / Group Name		TIN Number	
Facility / Group Address (where services will be rendered)		Facility / Group NPI	
City		State	Zip
Contact Person	Phone	Fax	
Treating Therapist Name (rendering)		Treating Therapist NPI	
Referring Provider Name		Referring Provider NPI	
Patient Last Name	Patient First Name	Patient ID	
Patient County		Patient Date of Birth (mm/dd/yyyy):	

Line of Business **Medicare** **Medicaid** **Medicaid Healthy Kids**

Place of Service **Office (11)** **Independent Clinic (49)** **Other [_ _]**

Primary Diagnosis Description

<input type="checkbox"/> ICD-9	ICD Code 1	ICD Code 2	ICD Code 3	ICD Code 4
<input type="checkbox"/> ICD-10				

If Status Post Surgery, List Procedure

Date of Surgery (mm/dd/yyyy)

For Cerebral Vascular Accident (CVA), list Date of CVA (mm/dd/yyyy):

Please check box to confirm

Member's Plan of Care has been submitted and approved by ordering Provider and the frequency and duration are:

_____ times/ per week _____ number of weeks

Please check box to confirm

Ordering Provider will be notified when therapy has been completed and whether the goals have been achieved (Member discharged) or Therapy was stopped

Please check box to confirm

The servicing provider has reviewed the approved Plan of Care with the Enrollee including the frequency and duration, and will provide these services.

STEP 1: FILL OUT SEPARATE PATIENT INTAKE FORM FOR EACH DISCIPLINE

Physical Therapy **Occupational Therapy** **Speech Therapy** Evaluation Date (mm/dd/yyyy):

TEST SCORE	Test Used	Test Results (Standard Deviation)	Test Result (Age Equivalency) _____ _____	<input type="checkbox"/> Month <input type="checkbox"/> Year

Note/Comments:

STEP 2: FOR EXTENDED EPISODE FEE (EEF) REQUESTS (After completion of Step 1 above, if patient needs continued therapy, complete below and fax to ATA-FL)

Since evaluation date: # visits scheduled: Number of Visits Attended: Date of Last Visit (mm/dd/yyyy):

STEP 3: APPLICABLE IF PATIENT IS IN CONTINUOUS THERAPY FOR 4 MONTHS (You may request an additional EEF Level by submitting the following information 4 months after eval date)

Since evaluation date: # visits scheduled: Number of Visits Attended: Date of Last Visit (mm/dd/yyyy):

Additional Information: