



EmblemHealth Benefit Extensions Treatment Plan

To be completed by the provider rendering therapy. Please print clearly or type, and complete the entire form.

Date of this request: ____ / ____ / ____		Fax no: 1-212-967-2995	
Patient last name:		Patient first name:	
Date of birth: ____ / ____ / ____	Sex: ☐ M ☐ F	Policy holder certificate no:	
Insured last name:		Insured first name:	Telephone no:
Name of provider rendering service:			Tax ID no:
Participating provider? ☐ Y ☐ N	Office contact:		Par provider no:
Telephone no: ()		Fax no: ()	
Referring physician (full name):			Telephone no: ()
Referring physician address:			
City:			State: ZIP code:
Medical History:			
Requested service (select one): ☐ PT ☐ OT ☐ ST ☐ MVA-related ☐ WC-Related ☐ Allergy - For allergy treatment, injection treatment start date (month/year): ____/____			
Date of illness onset: ____ / ____ / ____			
Positive objective findings and comorbidities:			
Diagnoses (description):		Associated surgery (for current diagnosis):	Date: ____ / ____ / ____
*ICD code(s): 1. _____ 2. _____ 3. _____			
% improved to date: ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%			
% improved from previous evaluation: _____		% improved from previous functioning before injury/illness: _____	
What is the expectation of maximum medical improvement (MMI) over time?			
Has therapy been continuous? ☐ Y ☐ N		Has patient been instructed in a home exercise program? ☐ Y ☐ N	
Number of visits to reach MMI: _____		Prognosis:	
From date: ____ / ____ / ____ To date: ____ / ____ / ____			
Start of care (this year):		Visits used to date (this year):	

*Effective October 1, 2014, EmblemHealth will support ICD-10 diagnosis codes.

Once a total of 32 visits (including base benefit) have been authorized for a particular treatment area, additional extension requests must be accompanied by a prescription from the attending physician with frequency and duration.

Note: The patient must be eligible for coverage at the time the actual services are rendered.

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