

First Choice

## From

From \_\_\_\_\_ Fax \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_  
E-mail \_\_\_\_\_

## Member Information

Last, first MI \_\_\_\_\_  
Medicaid ID # \_\_\_\_\_ DOB \_\_\_\_\_

## Procedure Information

Please select **ONE** of the following:

Physical Therapy       Occupational Therapy       Speech Therapy       Chiropractor

Diagnosis \_\_\_\_\_ Service start \_\_\_\_\_

CPT code \_\_\_\_\_ ICD9 code \_\_\_\_\_ No visits requested \_\_\_\_\_ Service end \_\_\_\_\_

## Provider Information

Provider name: last, first MI \_\_\_\_\_ Provider ID # \_\_\_\_\_

Address, city, state zip \_\_\_\_\_

Contact person \_\_\_\_\_ Fax \_\_\_\_\_ Call back # \_\_\_\_\_

## Practitioner Information

Practitioner name: last, first MI \_\_\_\_\_ State ID # \_\_\_\_\_

Address, city, state zip \_\_\_\_\_

Contact person \_\_\_\_\_ Fax \_\_\_\_\_ Call back # \_\_\_\_\_

**FAX request form with supporting clinical documentation to 866.368.4562.**

## Select Health Use Only

Case number \_\_\_\_\_ Date \_\_\_\_\_

Given by \_\_\_\_\_ Ext. \_\_\_\_\_