

Medi-Cal Field Office _____

MEDICAL JUSTIFICATION FOR THERAPY TREATMENT PLAN

Your request for prior authorization for Medi-Cal payment for therapy services to the patient named below must include the following information in order to be appropriately evaluated by the Medi-Cal Field Office. Please provide this information to the Medi-Cal Field Office.

Deadline for submitting the information, if any: _____ .

 Patient name

 Address

 Medi-Cal I.D. number

 Diagnosis and date of onset

 Date:

 Date of surgery (if applicable):

 Significant associated diagnoses

 Current medical status of patient and/or functional limitations

 Findings on initial evaluation

 Specific services prescribed, including amount, frequency, duration

 Therapeutic goals to be achieved by therapies and anticipated time for achievement of goals

 Anticipated medical outcome as a result of therapy

 The extent to which physical therapy, occupational therapy, speech therapy, or audiology services have been previously provided, and benefits or improvements demonstrated by such prior care.

 Other

 Physician's name

 Address

 Therapy provider's name

 Address

 Physician's signature

 Date