

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: (Optional if attaching face sheet)

Full Name(as on Insurance ID Card): _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell#: _____ Email: _____

Social Security#: _____ Date of Birth: _____

HCP/POA Contact: _____ Relationship _____

Phone#: _____ Email: _____

Agency/HHA: _____ Phone#: _____

Rx: by Referring MD/DO/DPM/NP (or attach your standard Rx):

Referrer Name: _____ NPI#: _____

Address: _____ Phone/Fax#: _____

Email: _____

I certify these services as medically necessary for the patient's plan of care.

Referring Provider **Signature**: _____ Date: _____

Rx Therapy: **Physical(PT)** **Occupational(OT)** **Speech/Swallow** **FEES**

Frequency/Duration: _____ **x/week for** _____ **Weeks.**

Diagnosis: _____

Medical History & Precautions: _____

Patient Insurance Information:

Primary Insurance#: _____ **Sec. Ins. Name/ #:** _____

In Network: Medicare United Health Care Empire BCBS(NY)
 Cigna (Out of Humana Medicare Aetna
 Network) Horizon BCBS(NJ)

Private Pay: **PT/OT/SLP** \$130 for(up to 60 minutes) per session

SLP - FEES \$250



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