Therapy Approval Form

Date: _____ Facility: _____

Resident Name: _____

Resident Rm No. _____ Current Facility Payer Source: _____

_____ does not have Part B or insurance benefits.

_____ does not qualify for Part B or insurance benefits.

_____ Other: _____

Per Administration:

☐ Skilled Therapy is authorized:

☐ PT	Freq _____	Duration _____	Units _____
☐ OT	Freq _____	Duration _____	Units _____
☐ ST	Freq _____	Duration _____	Units _____

☐ Restorative only is authorized: Frequency & Duration: _____

☐ No services are authorized.

Administrator Signature:

_____