DLN _____ Medicaid ID _____ Individual Name _____

Authorization Request for Nursing Facility Specialized Services (NFSS)

NFSS for Habilitative Therapies (OT, PT,ST)

Resident/NF

Resident Information

A0100A. First Name	A0100B. Middle Initial	A0100C. Last Name	A0100D. Suffix	A0200A. Social Security No.

A0200B. Medicare No.	A0300. Medicaid No.	A0400A. Birth Date	A0400B. Age at Time of Submission

Legally Authorized Representative (LAR) Information

A0500A. First Name	A0500B. Last Name

A0600A. Street Address	A0600B. City	A0600C. State	A0600D. ZIP Code

A0600E. Phone No.

Nursing Facility Information

A0700A. Provider No.	A0700B. Vendor No.	A0700C. NPI/API No.

A0700D. Facility Name	A0800A. Street Address	A0800B. City

A0800C. State	A0800D. ZIP Code	A0800E. County	A0900A. Phone No.	A0900B. Fax No.

LIDDA and LMHA Information

A1000A. LIDDA Provider No.	A1000B. LIDDA Vendor No.	A1000C. LIDDA NPI/API No.

A1100A. LMHA Provider No.	A1100B. LMHA Vendor No.	A1100C. LMHA NPI/API No.

Type of Service Requested

A2000. Request Type	Habilitative Therapies
A2300. Habilitative Therapies (Select all that apply)	☐ A. Occupational Therapy (OT) ☐ B. Physical Therapy (PT) ☐ C. Speech Therapy (ST)

DLN _____ Medicaid ID _____ Individual Name _____

Occupational Therapy (OT) Assessment

Authorization Type

E0100. Occupational Therapy Authorization Type (Select only one)

- ☐ 1. Assessment Only
- 2. New
- 3. Restart
- 4. Recertification

Therapist Identifying Information

E0200A. First Name

E0200B. Last Name

E0300A. License Type (Select only one)

- ☐ 1. Occupational
- 2. Physical

E0300B. License No.

E0300C. License State

E0400. Is the Therapist employed by the Nursing Facility?

- ☐ 0. No
- 1. Yes

If the Therapist is not employed by the Nursing Facility complete the remainder of the **Therapist identifying Information** section.

E0500. Therapist's Employer Name

E0600A. Street Address

E0600B. City

E0600C. State

E0600D. ZIP Code

E0700A. Phone No.

E0700B. FAX No.

E0800. Therapist's Signature Date

To be entered from the Attachment Therapy Signature Page.

Date of Assessment - Occupational Therapy

E0900. Date of Assessment

Therapy Assessment - Occupational Therapy

E1100. Treating impairment or dysfunction (minimum of 50 characters)

E1200. Initial Assessment/Current Level of Function and Underlying Impairments (minimum of 50 characters)

E1300. Clinical Impressions (minimum of 50 characters)

E1400. Reason for Skilled Services (minimum of 50 characters)

E1500. Skilled Intervention Focus (minimum of 50 characters)

DLN _____ Medicaid ID _____ Individual Name _____

Occupational Therapy (OT) Service

Therapy Treatment Plan - Occupational Therapy

If the Authorization Type is New or Restart this section is required.
If the Authorization Type is Recertification and a previous Recertification has not been entered on the LTC Online Portal, this section is required.
If the Authorization Type is Assessment Only, skip this section.

E1600A. Code (ICD-10)	E1600B. Description	E1600C. Date of Onset, if known

E1700. Long-Term Goals (minimum of 50 characters)

E1800. Short-Term Goals (minimum of 50 characters)

DLN _____ Medicaid ID _____ Individual Name _____

Recommended Habilitation - Occupational Therapy

E1900A. Frequency: No. of times per week (Select only one)

- ☐ 1. 1 time per week
- ☐ 2. 2 times per week
- ☐ 3. 3 times per week
- ☐ 4. 4 times per week
- ☐ 5. 5 times per week
- ☐ 6. 6 times per week
- ☐ 7. 7 times per week

E1900B. Duration: length of treatment (Select only one)

- ☐ 1. 1 month
- ☐ 2. 2 months
- ☐ 3. 3 months
- ☐ 4. 4 months
- ☐ 5. 5 months
- ☐ 6. 6 months

E1900C. Intensity: No of times per day the therapist provides treatment (Select only one)

- ☐ 1. 1 time per day
- ☐ 2. 2 times per day
- ☐ 3. 3 times per day

Referring Physician Identifying Information - Occupational Therapy

E2000A. Last Name	E2000B. License State	E2000C. License No.	E2000D. Military Spec Code

E2000E. Date Resident Last Seen

E2000F. Signature Date

To be entered from the Attachment Therapy Signature page.

Note: The following Physician information is required if Physician is <u>not</u> licensed in Texas.

E2100. First Name

E2200A. Street Address

E2200B. City

E2200C. State

E2200D. ZIP Code

E2200E. Phone No.

DLN _____ Medicaid ID _____ Individual Name _____

Physical Therapy (PT) Assessment

Authorization Type

E3100. Physical Therapy Authorization Type (Select only one)

- ☐ 1. Assessment Only
- 2. New
- 3. Restart
- 4. Recertification

Therapist Identifying Information

E3200A. First Name

E3200B. Last Name

E3300A. License Type (Select only one)

- ☐ 1. Occupational
- 2. Physical

E3300B. License No.

E3300C. License State

E3400. Is the Therapist employed by the Nursing Facility?

- ☐ 0. No
- 1. Yes

If the Therapist is not employed by the Nursing Facility complete the remainder of **Therapist Identifying Information** section.

E3500. Therapist's Employer Name

E3600A. Street Address

E3600B. City

E3600C. State

E3600D. ZIP Code

E3700A. Phone No.

E3700B. FAX No.

E3800. Therapist's Signature Date

To be entered from the Attachment Therapy Signature page.

Date of Assessment - Physical Therapy

E3900. Date of Assessment

Therapy Assessment - Physical Therapy

E4100. Treating impairment or dysfunction (minimum of 50 characters)

E4200. Initial Assessment/Current Level of Function and Underlying Impairments (minimum of 50 characters)

E4300. Clinical Impressions (minimum of 50 characters)

E4400. Reason for Skilled Services (minimum of 50 characters)

E4500. Skilled Intervention Focus (minimum of 50 characters)

DLN _____ Medicaid ID _____ Individual Name _____

Physical Therapy (PT) Service

Therapy Treatment Plan - Physical Therapy

If the Authorization Type is New or Restart this section is required.
If the Authorization Type is Recertification and a previous Recertification has not been entered on the LTC Online Portal, this section is required.
If the Authorization Type is Assessment Only, skip this section.

E4600A. Code (ICD-10)	E4600B. Description	E4600C. Date of Onset, if known

E4700. Long-Term Goals (minimum of 50 characters)

E4800. Short-Term Goals (minimum of 50 characters)

DLN _____ Medicaid ID _____ Individual Name _____

Recommended Habilitation - Physical Therapy

E4900A. Frequency: No. of times per week (Select only one)

- 1. 1 time per week
- 2. 2 times per week
- 3. 3 times per week
- 4. 4 times per week
- 5. 5 times per week
- 6. 6 times per week
- 7. 7 times per week

E4900B. Duration: length of treatment Select only one)

- 1. 1 month
- 2. 2 months
- 3. 3 months
- 4. 4 months
- 5. 5 months
- 6. 6 months

E4900C. Intensity: No of times per day the therapist provides treatment (Select only one)

- 1. 1 time per day
- 2. 2 times per day
- 3. 3 times per day

Referring Physician Identifying Information - Physical Therapy

E5000A. Last Name | E5000B. License State | E5000C. License No. | E5000D. Military Spec Code

E5000E. Date Resident Last Seen | E5000F. Signature Date

To be entered from the Attachment Therapy Signature page.

Note: The following Physician information is required if Physician is not licensed in Texas.

E5100. First Name

E5200A. Street Address | E5200B. City

E5200C. State | E5200D. ZIP Code | E5200E. Phone No.

DLN _____ Medicaid ID _____ Individual Name _____

Speech Therapy (ST) Assessment

Authorization Type

E6100. Speech Therapy Authorization Type (Select only one)

☐ 1. Assessment Only
2. New
3. Restart
4. Recertification

Therapist Identifying Information

E6200A. First Name

E6200B. Last Name

E6300A. License Type

3. Speech

E6300B. License No.

E6300C. License State

E6400. Is the Therapist employed by the Nursing Facility?

☐ 0. No
1. Yes

If the Therapist is not employed by the Nursing Facility complete the remainder of **Therapist Identifying Information** section.

E6500. Therapist's Employer Name

E6600A. Street Address

E6600B. City

E6600C. State

E6600D. ZIP Code

E6700A. Phone No.

E6700B. FAX No.

E6800. Therapist's Signature Date

To be entered from Attachment Therapy Signature Page.

Date of Assessment - Speech Therapy

E6900. Date of Assessment

Therapy Assessment - Speech Therapy

E7100. Treating impairment or dysfunction (minimum of 50 characters)

E7200. Initial Assessment/Current Level of Function and Underlying Impairments (minimum of 50 characters)

E7300. Clinical Impressions (minimum of 50 characters)

E7400. Reason for Skilled Services (minimum of 50 characters)

E7500. Skilled Intervention Focus (minimum of 50 characters)

DLN _____ Medicaid ID _____ Individual Name _____

Speech Therapy (ST) Service

Therapy Treatment Plan - Speech Therapy

If the Authorization Type is New or Restart this section is required.
If the Authorization Type is Recertification and a previous Recertification has not been entered on the LTC Online Portal, this section is required.
If the Authorization Type is Assessment Only, skip this section.

E7600A. Code (ICD-10)	E7600B. Description	E7600C. Date of Onset, if known

E7700. Long-Term Goals (minimum of 50 characters)

E7800. Short-Term Goals (minimum of 50 characters)

DLN _____ Medicaid ID _____ Individual Name _____

Recommended Habilitation - Speech Therapy

E7900A. Frequency: No. of times per week (Select only one)

- ☐ 1. 1 time per week
- ☐ 2. 2 times per week
- ☐ 3. 3 times per week
- ☐ 4. 4 times per week
- ☐ 5. 5 times per week
- ☐ 6. 6 times per week
- ☐ 7. 7 times per week

E7900B. Duration: length of treatment (Select only one)

- ☐ 1. 1 month
- ☐ 2. 2 months
- ☐ 3. 3 months
- ☐ 4. 4 months
- ☐ 5. 5 months
- ☐ 6. 6 months

E7900C. Intensity: No of times per day the therapist provides treatment (Select only one)

- ☐ 1. 1 time per day
- ☐ 2. 2 times per day
- ☐ 3. 3 times per day

Referring Physician Identifying Information - Speech Therapy

E8000A. Last Name | E8000B. License State | E8000C. License No. | E8000D. Military Spec Code

E8000E. Date Resident Last Seen | E8000F. Signature Date

To be entered from the Attachment Therapy Signature page.

Note: The following Physician information is required if Physician is not licensed in Texas.

E8100. First Name

E8200A. Street Address | E8200B. City

E8200C. State | E8200D. ZIP Code | E8200E. Phone No.