STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES

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

DHCS 6183 (9/09)