

SPEEDY RECOVERY

Link: 1-800-816-5465

Fax: 1-800-552-8633

Clinical Coordination Dept



Member Information

Requested Service

Date of Admission: ___/___/___

Member #: A _ _ _ _ _ - _ _

Member Name: _____ D.O.B: ___/___/___

TOTAL HIP

TOTAL KNEE

Right Left Bilateral

Authorization Information

ICD9 Code: _____ Diagnosis: _____

CPT Code(s): _____

Requesting Provider Information

MD Name: _____ MD Provider #: _____

MD Provider Tel. #: _____

MD Provider Fax #: _____

Office Contact Name: _____ Ext: _____

Hospital Name: _____ Hospital Provider #: _____

Service Required Prior to Admission and Upon Discharge

Home Health Care Name/Provider #: _____

Phone #: _____ Fax #: _____

Pre-Surgical: RN Evaluation, MSW Evaluation Post-Surgical: RN Evaluation + 3 visits

Therapy Provider Name/Provider #: _____

Pre-Surgical: Evaluation 97001 Post-Surgical: Evaluation + 3 visits

APRIA DME Provider # _____ Phone #: _____

*****FAX DME ORDERS TO DME PROVIDER*****

Cane E0100 (purchase) Wheelchair E1130 (rental x 3 months)

Walker E0130 (purchase) Other (Specify) _____

Comments: _____

Please submit clinical information to support medical appropriateness, including exhausted conservative treatment.