MAIL TO:
DXC / LA. MEDICAID
P.O. BOX 14919
Baton Rouge, La. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing

REHABILITATION SERVICES REQUEST

Patient Name: _____ Age: _____ Provider Name: _____

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY: _____

LIMITATIONS : ____ AMBULATORY ____ NON - AMBULATORY ____ YES ____ NO TRANSPORTATION AVAILABLE

AIDS NEEDED: ____ WALKER ____ CANE ____ WHEELCHAIR ____ LIMBS OR BRACES _____ OTHER

REHABILITATION PLAN

PLAN OF SERVICES: _____ INITIAL _____ EXTENSION

IF INITIAL , INITIAL EVALUATION DATA AND MD REFERRAL / PRESCRIPTION MUST BE ATTACHED

IF EXTENSION, PRIOR ATTENDANCE : _____ REGULAR _____ NON-REGULAR. MUST ALSO ATTACH PROGRESS REPORTS

REQUESTED SERVICES: PROCEDURE CODE DESCRIPTION FREQUENCY TIME / VISIT TOTAL UNITS

PHYSICAL THERAPY: _____

_____

_____

_____

SPEECH THERAPY: _____

_____

_____

_____

OCCUPATIONAL THERAPY _____

_____

_____

_____

LENGTH OF PLAN SERVICE: FROM: _____ TO : _____

MONTH DAY YEAR MONTH DAY YEAR

DATE OF RE – EVALUATION: _____

MONTH DAY YEAR

PROPOSED GOALS / COMMENTS: _____

_____

_____

_____

REQUESTED BY : _____ DATE: _____

P.A 02 FORM (ISSUED 01/91)