Colorado Choice Health Plans
Request for Additional Rehabilitative Services

FAX: 719.589.4995 Email: medical@cochoice.com

Please attach progress notes with this completed request.

Member Name: ______________________ ID#: ______________ DOB: ______________
Please Print

Who should we contact if we have follow up questions?
Sender: ______________________ Phone: ______________ FAX: ______________

Physician Name: ______________________ Agency: ______________________

What type of follow up therapy is requested: ☐ PT ☐ OT ☐ ST

When requesting additional visits for therapy, we need the following information:

1. ICD-10 diagnosis ______________________
2. What functional improvements have been documented so far? ______________________
3. Describe continued limited functioning: ______________________
4. Please outline HEP or patient education that has been done, to date: ______________________
5. Please list specific functional goals that will be achieved with continued therapy: ______________________
6. What additional education is planned? ______________________

______________________ ______________
Signature/Therapist (forward to therapist if necessary) Date