

# Upgrade Request Form

Attach documentation supporting the patient's current diagnosis and the reason for the upgrade request

Phone: (855) 825-7818 | Fax: (877) 583-6440

|                             |                |
|-----------------------------|----------------|
| Facility Requesting Upgrade | Contact Person |
| Phone                       | Fax            |

ST       OT       PT

|                                   |                     |                        |                     |
|-----------------------------------|---------------------|------------------------|---------------------|
| Patient's Name                    |                     |                        | Date of Birth       |
| Member ID Number                  | Current Level/Visit | Requesting Level/Visit | Current Referral No |
| Current Diagnosis                 |                     |                        | Date of last visit  |
| How many visits completed (dates) |                     |                        |                     |

## FOR OFFICE USE ONLY

|                      |                       |
|----------------------|-----------------------|
| Date TN received fax | Date request reviewed |
| Referral History     |                       |
| Recommended Level    |                       |
| Comments             |                       |

**Additional Comments:**

Not enough information received. Please send additional objective clinical information, including initial evaluation and treatment notes, for further review.

No upgrade at this time. Please continue to treat patient and send objective progress notes for further review. Your request will be reconsidered.

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