

MAIL TO:
Molina / 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: _____