

Therapy Billing Summary Form



Fax this completed form to 855-622-7973.

Member name _____ Authorization number _____

Facility name _____ Facility contact _____

Facility phone _____ Attending provider _____

Diagnosis _____

| Date of service | Physical therapy minutes | Occupational therapy minutes | Speech therapy minutes | Total | Level |
|-----------------|--------------------------|------------------------------|------------------------|-------|-------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |