



Speedy Recovery Program

Fax Request to 1-866-440-4628 Authorization Number: _____
(Valid for 90 days from date of request)

TOTAL HIP REPLACEMENT or TOTAL KNEE REPLACEMENT

This form may be returned unprocessed if not completely filled out with all requested information.
DO NOT use this form for authorizations that need immediate response (urgent). Please call 1-866-773-1072

Member Information

Member ID#: _____ Member Name: _____
Member DOB: ____ / ____ / ____ County: _____ Request Date: ____ / ____ / ____

Requesting Provider Information

Provider ID#: _____ Provider Referral from PCP: Yes No
Provider Name: _____ Contact Name: _____
Phone #: _____ Fax #: _____

Post Surgical Care - Home Health Care Provider Information

Authorization Number: _____ Contact Name: _____
Provider ID#: _____ Phone #: 855-224-2558
Home Health Agency Name: Univita

- Skilled Nursing - (G0154)** 1 RN eval & 2 visits X 2 weeks = total 5 visits Date to Begin: ____ / ____ / ____
 Alternate plan of care for Skilled Nursing _____ Date to Begin: ____ / ____ / ____
- Physical Therapy - (G0151)**
 for Total Hip Replacement = 1 PT eval + 5 PT visits over 3 weeks Date to Begin: ____ / ____ / ____
 for Total Knee Replacement = 1 PT eval + 6 PT visits over 5 weeks Date to Begin: ____ / ____ / ____
- Additional Services - Specify** _____

Post Surgical Care - Outpatient Rehabilitation Provider Information

Authorization Number: _____ Contact Name: _____
Provider ID#: _____ Phone #: _____
Rehab Facility Name: _____

- Physical Therapy - (for TKR only)** 7 visits = 1 eval + 3x a week for 2 weeks Date to Begin: ____ / ____ / ____
 outpatient PT to include Physical Therapy Evaluation (97001) X1, Therapeutic Activities (97530) X6, Gait training (97116) X6,
Manual Therapy (97140) X6, Ultrasound Therapy (97035) X6 & Electrical Stimulation (97032) X6
- Additional Services - Specify** _____

Post Surgical Care Supplies Information

Authorization Number: _____ Contact Name: _____
Provider ID #: _____ Phone #: 855-224-2558
DME Provider Name: Univita

- CPM Machine - code E0936 Cane - code E0100 or E0105 Crutches - code _____
- Walker - code _____ Wheelchair - code _____ 3-in-1 commode - code _____

This request cannot be processed without supporting clinical documentation, such as: office visit notes, pertinent laboratory data, prior treatment note(s), etc. Receipt of this referral does not guarantee reimbursement. Reimbursement is subject to benefit coverage and patient eligibility at the time services are rendered.

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