# Friday Health Plans
# Request for Additional Rehabilitative Services

FAX: 719.589.4995 Email: medical@fridayhealthplans.com

friday health plans of colorado

**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