General Assistance Medical Program

Request for Therapy

Date:_____ Providers Tax ID Number:_____

Provider:_____ Phone No: _____ Fax No._____

Patient Last Name:	Patient first Name:
D.O.B.	**Gamp Effective Dates**:
SSN.	From: To:
Medical Diagnosis:	
Request for: ☐ OT ☐ PT ☐ Speech ☐ Cardiac Rehab	Previous treatment site for this diagnosis (if Applicable):
Date of Initial Evaluation: Number of Visits to date at your site:	# of Visits:

Part A

Problem List	**Procedures (skilled)**

Short Term Goals	**Expected Completion Date**
1.	
2.	
3.	
Long Term Goals	**Expected Completion Date**
1.	
2.	
3.	

Requested Frequency/Duration _____x/week for _____weeks**.**

Please send copy of initial evaluation

Part B

FOR ADDITIONAL VISITS COMPLETE – BELOW (beyond those requested above)

Long Term Goals	**Degree of Goal Completion to Date**
1.	%
2.	%
3.	%

Requested Frequency/Duration _____x/week for _____weeks

Please send progress notes from:_____to_____dates

********** For GAMP Utilization Management use only **********

Todays Date:	Authorization No:
Signature:	Service Authorized:

. Authorized Fee at GAMP Reimbursement Schedule. Issuance of number indicates medical necessity, and does not necessarily guarantee payment of services

Fax form to (414)289-8516 Utilization Management : Telephone # 289-6731