maryland physicians care
Medicaid with a Heart

Please complete <u>BOTH</u> the Outpatient Prior Authorization Request From and the Cardiac Rehabilitation Form and Fax to 1-800-953-8856

Cardiac Rehabilitation Pre-Authorization Form

Incomplete forms may result in delay of decision or denial of services.

1. Member Name: _____ DOB: _____
Member ID #: _____

2. Initial Request _____(12 visits) Ongoing Request _____(≤ 24 visits)

3. Recent Hospitalization with Cardiac Diagnosis?
Yes _____ If Yes, When? _____ Diagnosis? _____
No _____ If No, has a Stress Test Been Completed? _____ (please include copy of test results)

4. Does the Member Agree to Program Participation? Yes _____ No _____
Please select therapy that will be addressed during Cardiac Rehabilitation:

	Yes	No	N/A
Therapy Program:			
Home Therapy Program and Self-Management			
Exercise Training and Physical Activity Counseling			
Psychosocial Management			
Nutritional Counseling			
Lipid Counseling			
Blood Pressure Counseling			
Diabetes Counseling			
Smoking Cessation			
Medication Education/Management			
Goals:			
Lifestyle Management			
Secondary Prevention			

5. If this is an **Ongoing Request**, has partial progress been made in meeting therapy goals?

	Yes	No
Reduction in intensity and frequency of symptoms or findings		
Improvement in function and reduction in limitations		
Independence in self-management		
Adherence to HEP		

6. Prescriber's Signature: _____ NPI #: _____
Prescriber's Name (Printed): _____ Date: _____