



Please complete BOTH 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. **Please Select Only ONE:** Initial Request \_\_\_\_\_ Ongoing Request \_\_\_\_\_

\*\*\*Initial and ongoing request cannot be determined at the same time. \*\*\*

\*\*\*A new form must be submitted for ongoing visits and question 5 must be completed. \*\*\*

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:

<b>Initial Request</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
<b>Therapy Program:</b>			
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			
<b>Goals:</b>			
Lifestyle Management			
Secondary Prevention			

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

<b>Ongoing Request</b>	<b>Yes</b>	<b>No</b>
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: \_\_\_\_\_