



# Upgrade Request Form

Attach documentation supporting the patient's current diagnosis and the reason for the upgrade request  
Phone **(855) 825-7818** | Fax **(877) 583-6440**

Facility Requesting Upgrade	Contact Person
Phone	Fax

ST       OT       PT

Patient's Name			Date of Birth
Member ID Number	Current Level/Visit	Requesting Level/Visit	Current Referral No
Current Diagnosis			Date of last visit
How many visits completed (dates)			

## FOR OFFICE USE ONLY

Date TN received fax	Date request reviewed
Referral History	
Recommended Level	
Comments	

**Additional Comments:**

\_\_\_\_\_ Not enough information received. Please send additional objective clinical information, including initial evaluation and treatment notes, for further review.

\_\_\_\_\_ No upgrade at this time. Please continue to treat patient and send objective progress notes for further review. Your request will be reconsidered.

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