THERAPY NETWORK
OF NEW JERSEY

Patient Intake Form

Please Fax To Therapy Network
Authorization Department: **(855) 825-7820**
Phone Inquiries: **(855) 825-7818**

General

Date of Request	Type of Service	Place of Service
	☐ Routine ☐ Urgent (Medically necessary within 72 hours)	☐ Office ☐ Out Pt. Hospital

Submit separate Form for each type

☐ PT ☐ OT ☐ ST ☐ Other:

Member Information

Member Name: (Last, First, M)	Date of Birth	Member ID

Street Address	City	ST	Zip	Phone

PCP

Ordering Provider Name (PCP)	Ordering PCP Phone	Ordering PCP Fax

Therapy Provider Information

Are you currently contracted with TNNJ?	Individual Treating Provider Name
☐ Yes ☐ No	

Therapy Facility Name

Phone Number	Fax Number	NPI	Tax ID #

Street Address	City	ST	Zip

Required Information

Diagnosis Treatment	ICD-10 Codes

Other Info: (e.g. surgery, list procedure and date of surgery)

Date of Evaluation	Plan of Treatment

For school aged children, submit IEP, or reason for non-availability of IEP	Number Visits Completed	Date of Last Visit

I, the undersigned, hereby attest that the information provided above is accurate and truthful to the best of my knowledge and belief.

Provider or Authorized Representative Signature **Print Name** **Date**