**Department of Vermont Health Access**

**Request for Re/habilitation Therapy Services: ADULT NON-HOME HEALTH**

**As of 1/1/23, prior authorization for Physical Therapy, Occupational Therapy, and Speech Language Pathology treatment (PT, OT, and ST) is required for all outpatient non-home health services, regardless of Accountable Care Organization attribution, beyond 30 combined PT, OT, and ST visits. Each discipline must complete a separate form.**

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| Member’s Legal Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Member Birthdate: \_\_\_/\_\_\_/\_\_\_\_\_  Member Unique ID#: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Supplying Provider Facility: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Supplying Provider Facility #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Referring Physician/Advanced Practice Provider Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Referring Physician/Advanced Practice Provider #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Modifiers and Revenue Codes:**  Check One: PT GP 420-424 OT GO 430-434  ST  GN 440-444  Brief clarification of any events complicating therapy (for example, surgeries, illnesses, changes in family structure: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Commitment/Adherence to home program: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  If there are adherence concerns, document the plan for adherence improvement: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Is the condition a result of a motor vehicle accident? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Is the condition a result of a work-related accident? If so, specify why Worker’s Compensation or Social Security Disability Insurance is not the proper coverage source: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Underlying condition driving the care plan (primary billing diagnosis):**  ICD-10 dx code: **\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_**  Definition: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date of onset: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Other Dx**:** ICD-10 dx codes: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Definition: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date of onset: \_\_\_/\_\_\_/\_\_\_\_\_  Note: the ICD-10 codes for the above conditions must also appear on your claim forms. Do not use pain codes as the underlying condition unless there is a diagnosed pain syndrome. Include surgical aftercare information and coding if there has been a pertinent surgery. |

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|  | **Column 1** | **Column 2** | **Column 3** |
|  | **Report Period** | **Objective, measurable, member-oriented goals, and research-based treatment plan** | **Goals met/not met (check one). If not met, show progress toward each goal using initial and current objective parameters** |
| **Introductory section** | First 30 combined therapy visits  Date of initial therapy for any non- inpatient re/hab therapy services including home health and outpatient, any pay source, regardless of previous discharges and regardless of Accountable Care Organization attribution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Visit frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Avg. minutes/treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I have reviewed the treatment plan and goals and agree with the plan of care.  Physician/Advanced Practice Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | Goal 1:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 2:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Care coordination with other medical model disciplines and community supports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treatment plan including specific procedures, modalities, and family/caregiver training:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Procedure codes (codes must match treatment plan): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Transition planning:  \*Vocational rehabilitation (HireAbility)  \*VT Center for Independent Living  \*Required for members with long term conditions  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Goal 1 met not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 2 met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3 met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Therapist’s professional signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Credentials (check one): PT OT SLP-CCC  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |

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|  | **Column 1** | **Column 2** | **Column 3** |
|  | **Report Period** | **Objective measurable, member-oriented goals, and research-based treatment plan** | **Goals met/not met (check one). If not met, show progress toward each goal using initial and current objective parameters** |
| **First request section** | First request for treatment  Date after 30 combined therapy visits: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested end date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested frequency or # of visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Avg. minutes/treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I have reviewed the treatment plan and goals and agree with the plan of care.  Physician/Advanced Practice Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | Goal 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Care coordination with other medical model disciplines and community supports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treatment plan including specific procedures, modalities, and family/caregiver training:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Procedure codes (codes must match treatment plan): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Transition Planning:  \*Vocational Rehabilitation (HireAbility)  \*VT Center for Independent Living  \*Required for members with long term conditions  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Goal 1 met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 2 met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3 met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Therapist’s professional signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Credentials (check one): PT OT SLP-CCC  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |

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|  | **Report Period** | **Objective, measurable, member-oriented goals and research-based treatment plan** | **Goals met/not met (check one). If not met, show progress toward each goal using initial and current objective parameters** |
| **Second request section** | Second request for treatment  Requested start date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested end date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested frequency or # of visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Avg. minutes/treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I have reviewed the treatment plan and goals and agree with the plan of care.  Physician/Advanced Practice Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | Goal 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Care coordination with other medical model disciplines and community supports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treatment Plan including specific procedures, modalities, and family/caregiver training:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Procedure codes (codes must match treatment plan): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Transition planning:  \*Vocational Rehabilitation (HireAbility)  \*VT Center for Independent Living  \*Required for members with long term conditions  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Goal 1 met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 2 met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3 met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Therapist’s professional signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Credentials (check one): PT OT SLP-CCC  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |

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| **Third request section** | Third request for treatment  Requested start date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested end date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  Requested frequency or # of visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Avg. minutes/treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I have reviewed the treatment plan and goals and agree with the plan of care.  Physician/Advanced Practice Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | Goal 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Care coordination with other medical model disciplines and community supports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treatment Plan including specific procedures, modalities, and family/caregiver training:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Procedure codes (codes must match treatment plan): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Transition planning:  \*Vocational Rehabilitation (HireAbility)  \*VT Center for Independent Living  \*Required for members with long term conditions  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Goal 1 met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 2 met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goal 3 met  not met :  Data from the start of the certification period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Therapist’s professional signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Credentials (check one): PT OT SLP-CCC  Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |

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| **REQUESTS FOR REHABILITATION THERAPY SERVICES: ADULT** | **INSTRUCTIONS FOR USE OF THE DVHA MEDICAID FORM FOR ADULT THERAPY SERVICES** |
| Physical and occupational therapy services and speech language pathology services are routinely covered for 30 combined visits per calendar year on initial Physician/Advanced Practice Provider referral for any non-inpatient re/hab therapy services, regardless of pay source or history of discharges/readmissions. The supplying provider is responsible for contacting the referring provider to determine the start of care date.  A written request by the therapy practitioner to extend the period of treatment beyond the first 30 combined PT, OT, and ST visits and any subsequent authorization periods must be endorsed by the referring provider and submitted to the DVHA. It is recommended that the submission be prior to the expiration of the current period to avoid interruption of payment.  **For any clinical questions please contact the DVHA Physical Therapist at**  **The request must include:**   * Member name, date of birth and Medicaid unique ID. * Supplying provider facility name and VT Medicaid provider number. This is the provider/facility that will be receiving payment. * Name of referring Physician/Advanced Practice Provider and their VT Medicaid provider number. If a specialist has initiated the treatment, it is recommended that, when medically indicated, the subsequent endorsements be obtained from the primary care provider. * Date of initial therapy by any non-inpatient home/community-based therapy practitioner/facility regardless of pay source or history of discharges/readmissions. * Date and brief statement of events complicating therapy that affect Medicaid service, including , surgeries, illnesses, changes in family structure. * Care coordination with other team members, including other medical disciplines, and community resources including Vocational Rehabilitation (HireAbility) and the VT Center for Independent Living. * Documentation regarding adherence/commitment to the home program. If adherence has been an issue, document the plan to maximize adherence. * Primary billing diagnosis, and other relevant diagnoses, ICD-10 diagnosis codes and dates of onset. The primary billing diagnosis must be the primary medical condition which underlies the functional problems encountered by the member. Documented diagnoses must match billing diagnoses. Do not use pain codes as the underlying condition unless there is a diagnosed pain syndrome. Include surgical aftercare information and codes if there has been a pertinent surgery. * Final date of the introductory 30 combined PT, OT, and ST visit period. * Average minutes per treatment during the introductory 30 combined visit period. * Training of caregivers including direct training of paid personal care attendants if applicable. Use of new codes 97550-97552 requires documentation of the unique situation where there is a need to provide caregiver education in the interest of the member, without the member present.      * Objective, measurable, functional goals for the introductory 30 visit period. * Research based treatments/procedures provided during the introductory 30 visit period. A discharge plan must be put in place at the time of the initial evaluation. * Progress toward each unmet goal using objective parameters. Provide both initial and current data to clearly show the progress to date. * If goals were not met, an explanation of why they were not met. * Initial and final dates of the upcoming authorization period for which therapy is being requested. * Frequency or number of therapy visits being requested for the upcoming authorization period. * Average minutes per treatment for the upcoming authorization period. * Objective, measurable, functional goals for the upcoming authorization period. * Research based treatments/ procedures to be provided during the upcoming authorization period. * Date and Therapist’s signature with professional designation. * Date and signature of Physician/Advanced Practice Provider, demonstrating endorsement of the care plan. * Procedure codes and modifiers.   This information can be provided by use of this therapy form or by. the use of the DVHA Therapy Cover Sheet and clinical documentation as required by that form. Any additional attachments which further clarify the member’s medical status and treatment are welcome. | **FIRST SUBMISSION OF THIS FORM:**  FILL OUT **COMPLETELY** BEFORE THE INTRODUCTORY COMBINED 30-VISIT PERIOD IS OVER:   * Page 1 of form with basic information. * Introductory section, columns 1, 2, and 3. * First request, columns 1 and 2.   **SECOND SUBMISSION OF THIS FORM:**  FILL OUT **COMPLETELY** PRIOR TO THE EXPIRATION OF THE PREVIOUS CERTIFICATION PERIOD:   * First request, column 3 * Second request, columns 1 and 2.   **THIRD SUBMISSION OF THIS FORM:**  FILL OUT **COMPLETELY** PRIOR TO THE EXPIRATION OF THE PREVIOUS CERTIFICATION PERIOD:   * Second request, column 3. * Third request, columns 1 and 2.   **ADDITIONAL SUBMISSIONS IF THE FORM IS FULLY USED:**  Begin a new copy of the form and proceed as above. Note that the response area expands when the form is completed electronically.  This form is part of the medico-legal record. Corrections should be a single strike-out, with the date and your initials. Do not erase, scribble, or use liquid paper (white-out). This document may be viewed by lay readers including federal and state auditors and legal personnel. All documentation must be written such that the lay reader can clearly see the medical necessity of the goals and plan. For example, vocational and avocational/sports/leisure goals are not clearly medical in nature. Functional goals are particularly understandable to lay readers. Note also that goals related to school or work are not covered, because they are covered by other coverage sources.  Please save a copy of this form for your records. The Medicaid copy can be sent to the DVHA: NOB 1 South 280 State Drive, Waterbury VT 05671-1010 or faxed to (802) 879-5963. For clinical questions regarding therapy, including in servicing, documentation, and coverage, call the DVHA physical therapist at (802) 879-5903. For prior authorization (PA) status and billing issues please call DVHA’s fiscal agent Gainwell Technologies Provider Services at (800) 925-1706. |