



11 Fairfield Boulevard, Wallingford, CT 06492
(800) 440-5071 Fax (203) 265-3994 www.chnct.org

CHNCT THERAPY REQUEST FORM

Member's Name: _____ Date of Birth: _____

Member ID: Plan: Husky _____ Charter Oak _____

Provider: _____ Name of Contact: _____

Ordering MD: _____

Please print the ordering physician's FULL name and address *clearly* as we *cannot* process your request without this important information!

Treatment Plan: _____/wk x _____ weeks

Services Requested: Physical Therapy: _____ Chiro: _____ Occupational Therapy: _____

Speech Therapy: _____ School Evaluation: _____ PPT: _____ Birth to Three: _____

Audiology (92506): _____

Appt Date: _____ Diagnosis: _____

Phone: _____ Contact Fax: _____

**For extension or additional visits, please provide updated/current clinical notes.
Extensions/Additional visits will not be authorized without updated/current notes.**

Clinical notes must be faxed to CHNCT for review
Please fax request to 203-265-3994. Thank You

****PLEASE ALLOW 2 BUSINESS DAYS FROM RECEIPT OF
ALL CLINICAL INFORMATION TO PROCESS REQUEST****