TREATMENT AUTHORIZATION

PHYSICAL THERAPY

Injured Party Information

Please fill out the form completely.

Patient Name*:

DOB*:

Date of Accident*:

Referring Provider Name (RP):

Primary Phone*:

Email*:

Recommended Therapy Information

Treating Facility*:

Date of Initial Visit*:

How Many Visits Completed to Date?*

Total Recommended # of visits* (including initial visit)

Next Appt. Date*:

CPT Coding for Therapy:

Attorney Information

Firm Name*:

Contact at Firm*:

Phone*:

Fax:

Email:

Submit form via email to PreAuth@RedRockDiagnostics.com

FAX: (702)202-2052

Please include the patient-signed 2-page Red Rock Intake Form.

Questions? Call us: 980-800-6991