American Therapy Administrators, LLC

Authorization Form

N92 W14612 Anthony Avenue, Menomonee Falls, WI 53051

Phone: (888) 560-6855

Fax: (866) 231-6344

Contact Person | Telephone Number | Fax Number

Please include copy of insurance card or member service phone number from card

Primary Insured's Information

Primary Insured's Name (legal name, not nick names) | Primary Insured's Member Id | Insured's Date of Birth

Address | City | State | Zip Code

☐ Yes ☐ No Member has other Primary Insurance

If "Yes", Type of Primary Insurance

☐ Yes ☐ No Provider Needs Secondary EOB

Patient Information

Patient's Name (legal name, not nick names) | Patient's Member Id | Patient's Date of Birth

Address (if different from the insured) | City | State | Zip Code | Type of Plan

PCP Dr. Name | PCP Phone Number

Referring Physician Name (if different than PCP) | Referring Physician Phone Number (if different than PCP)

Treatment Information

Therapy Office Name | Therapy Office Address | City | State

Treating Therapist Name

○ PT ◉ OT ○ ST

Please check

Diagnosis Descriptions	ICD10 Codes
1.	1.
2.	2.
3.	3.
4.	4.

Evaluation Date/1 DOS (after prior referral expired)

Surgery Date (if applicable)

☐ Initial Referral ☐ Continued Referral

Please check one

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