



HAMASPIK CHOICE

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REQUEST FOR CONTINUATION OF SKILLED SERVICE

Please complete this form in its entirety

Requests are due on the 15th of the month (15 days prior to the authorization expiration date)

Member Name:	
Member DOB:	
Service Discipline:	

Indication for continued services:	
Progress made since last request (or since evaluation visit):	
Short term goals:	
Long term goals:	
Request for continued services (frequency x duration)	
Anticipated discharge date from services:	
Indication that without the service member would deteriorate/decompensate	

Clinician Name:	
Clinician Signature:	
Agency:	
Clinician Phone Number:	
Clinician e-mail:	