CASE MANAGEMENT TOOLKIT

Case coordination, insurance tracking and pediatric therapy follow-up

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CASE MANAGEMENT WORKFLOW

1. Referral & intake: Confirm demographics, requested discipline(s), referral/order requirements and clinical concerns.

2. Benefits & authorization: Verify eligibility, benefits, authorization requirements, approved visits/units and effective dates.

3. Evaluation & plan of care: Coordinate evaluation, goals, recommended frequency and required provider signatures/orders.

4. Scheduling & service coordination: Match the child with the appropriate clinician and location; identify barriers to care.

5. Utilization & progress: Track visits/units, authorization expiration, progress reports and recertification needs.

6. Communication & transition: Document follow-up with caregivers, providers, schools/PPECs and payers through discharge or transfer.

MASTER CASE SNAPSHOT

Patient Name: _____	**DOB:** _____
Parent / Guardian: _____	**Phone:** _____
Primary Insurance: _____	**Member ID:** _____
Referring Provider: _____	**NPI:** _____
Diagnosis / ICD-10: _____	**Case Manager:** _____

SERVICES

☐ Speech-Language Therapy ☐ Occupational Therapy ☐ Physical Therapy

Service Location: Home / School / PPEC / Clinic / Other: _____

Primary Clinical Concerns:
_____
_____

CURRENT CASE STATUS

Referral Received: _____	**Evaluation Date:** _____
Start of Care: _____	**Current Frequency:** _____
Authorization Status: _____	**Next Review Date:** _____
Current Barrier / Action Needed: _____ _____	**Responsible Party:** _____ **Due Date:** _____

INSURANCE & AUTHORIZATION TRACKER

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ELIGIBILITY / BENEFITS VERIFICATION

Payer: _____	**Plan / Product:** _____
Eligibility Verified: _____	**Effective Date:** _____
Representative / Reference #: _____	**Portal / Method:** _____
Referral Required? Yes / No **Authorization Required?** Yes / No	**Copay / Coinsurance:** _____ **Other Benefit Notes:** _____

AUTHORIZATION DETAILS

Discipline: Speech / OT / PT	**Authorization #:** _____
Approved From: _____ **To:** _____	**Approved Visits / Units:** _____
Used: _____ **Remaining:** _____	**Status:** Pending / Approved / Denied
Next Request Due: _____	**Submitted:** _____

Authorization / Follow-up Notes:

_____

_____

DOCUMENT CHECKLIST

☐ Referral / Order	☐ Insurance Card	☐ Evaluation	☐ Plan of Care
☐ Authorization	☐ Progress Report	☐ Provider Signature	☐ Other

Missing Documentation / Follow-up Needed:

_____

_____

PAYER CONTACT LOG

Date: _____ **Contact/Dept:** _____ **Ref #:** _____
Outcome: _____

Date: _____ **Contact/Dept:** _____ **Ref #:** _____
Outcome: _____

Date: _____ **Contact/Dept:** _____ **Ref #:** _____
Outcome: _____

PROGRESS & UTILIZATION TRACKER

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THERAPY PROGRESS SUMMARY

Reporting Period: _____	**Discipline:** Speech / OT / PT
Current Frequency: _____	**Therapist:** _____

Progress Toward Goals:

_____
_____
_____

Functional Gains / Caregiver Report:

_____
_____

Barriers Affecting Progress:

_____
_____

VISIT / UNIT TRACKING

Authorized: _____	**Completed:** _____
Cancelled: _____	**No-Shows:** _____
Remaining: _____	**Authorization Ends:** _____

NEXT ACTIONS

☐ Continue plan	☐ Reauthorization	☐ Update order	☐ Care conference
☐ Follow-up	☐ Attendance action	☐ Discharge planning	☐ Other

Action Details:

_____
_____

Assigned To: _____	**Due Date:** _____

CASE MANAGER NOTES

_____
_____
_____
_____
_____

CARE COORDINATION & COMMUNICATION LOG

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CONTACT LOG

Date / Time: _____ **Contact:** Parent / Provider / School / PPEC / Payer / Other
Person: _____ **Method:** Phone / Email / Portal / In Person
Discussion / Outcome: _____
Follow-up: _____ **Due:** _____

Date / Time: _____ **Contact:** Parent / Provider / School / PPEC / Payer / Other
Person: _____ **Method:** Phone / Email / Portal / In Person
Discussion / Outcome: _____
Follow-up: _____ **Due:** _____

Date / Time: _____ **Contact:** Parent / Provider / School / PPEC / Payer / Other
Person: _____ **Method:** Phone / Email / Portal / In Person
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Follow-up: _____ **Due:** _____

Date / Time: _____ **Contact:** Parent / Provider / School / PPEC / Payer / Other
Person: _____ **Method:** Phone / Email / Portal / In Person
Discussion / Outcome: _____
Follow-up: _____ **Due:** _____

CASE CLOSURE / TRANSITION

Status: Active / On Hold / Transferred / Discharged	**Effective Date:** _____
Reason: Goals Met / Authorization Ended / Attendance / Family Request / Transfer / Other	
Transition / Discharge Notes: _____ _____	
Case Manager: _____	**Date:** _____

Internal-use note: This toolkit supports case coordination and tracking. It does not replace payer-specific requirements, clinical documentation, plans of care, provider orders, authorizations, or other required records.