



**Utilization Management**  
**Phone: 1-877-284-0102      Fax: 1-800-510-2162**

**Physical/Occupational Therapy Precertification Review**

Date: \_\_\_\_\_ Reference #: \_\_\_\_\_ (provided after initial review)  
*A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care department. If you have any questions, please call Healthlink at 1-877-284-0102.*

**A copy of the physician's order for services and the initial evaluation are required prior to review of the requests of initial and ongoing services.**

**Provider Information**

Provider/Facility Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 TIN: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_  
 ID Number: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Patient DOB: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**Ordering Physician Information**

Physician Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 TIN: \_\_\_\_\_

**Treatment Information**

Is the doctor script/order on file?     YES     NO  
 Type of Service:             Physical Therapy             Occupational Therapy  
 Dates of Initial Visit: \_\_\_\_\_  
 Primary Diagnosis: \_\_\_\_\_  
 Diagnosis (ICD-9) Code: \_\_\_\_\_  
 Secondary Diagnosis: \_\_\_\_\_  
 Diagnosis (ICD-9) Code: \_\_\_\_\_  
 Frequency of Visits: \_\_\_\_\_  
 No. of Visits: \_\_\_\_\_  
 Projected Release Date to Home Exercise Program: \_\_\_\_\_  
 Length of Treatment: \_\_\_\_\_

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

	Initial Evaluation	Current Status
Date		
Pain Level		
Range of Motion		

	Initial Evaluation	Current Status
Strength		
Treatment Plan		
Measurable Goals (Avoid using WNL and WFL)		
Assistance with Other (ADL, Ambulation)		
Comments		
Next Doctor Appt.		

**Provider Contact Information**

Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_