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: _____

****ICD10 Procedure and Diagnosis codes will be utilized for Date of Service/Date of Admission/Date of Discharge after mandated compliance date.**

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: _____

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