PhysMetrics

PHYSICAL THERAPY - REHABILITATION
PRETREATMENT CERTIFICATION FORM

Submission Date: _____

Patient Name: _____ **DOB**: ____/____/_____ **Age**: _____ **Sex**: ☐ M ☐ F

Insurance ID #: _____ **Occupation**: _____

Insurance Plan/Employer: _____

Treating Provider Name (Print Clearly): _____

Treatment for Accident/Injury: ☐ Yes ☐ No **Date Occurred**:_____ **Type**: ☐ Auto ☐ Work ☐ Other

Date of: Onset: _____ **Patient's First Visit:** _____ **Patient's Most Recent Visit:** _____

The following documents must be submitted with this form for consideration.

☐ **Valid Prescription** ***(REQUIRED – must include information listed below)***

- Frequency & duration
- Diagnosis (ICD-10) Please List: _____
- Prescribing physicians signature and date signed

☐ **Physical Therapy Evaluation** ***(REQUIRED – must include clinical information listed below)***

- History of Condition
- Prior Level of Functioning
- Imagining/Op/Referring Physicians Report Summation
- Objective Testing
- Functional Outcome Testing
- Primary Functional Limitation Issue
- Primary Functional Goal
- Assessment (Summarizing all previously identified information)
- Short Term Goals
- Long Term Goals
- Plan of Care

☐ Other (as needed): _____

Requested CPT code(s) / Frequency: _____

Retro-Approval Requested: ☐ Yes ☐ No *If yes, date requested:* _____ *reason needed:* _____

Treating Provider Signature: _____ **Date:** ____/____/____ **Fax #:** _____

Please complete form legibly and fax with required documents to: 888-439-4819