PhysMetrics

OCCUPATIONAL THERAPY - HABILITATIVE
PRETREATMENT CERTIFICATION FORM

Submission Date: _____

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

Insurance ID #: _____ **Insurance Plan/Employer**: _____

Occupation/School: _____

Parent/Caregivers Name(s): _____

Treating Provider Name (Print Clearly): _____

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

☐ **Occupational Therapy Report** ***(REQUIRED – must include clinical information listed below)***

- History of Condition and/or Baseline
- Coordination of Care (include care provided by all specialties in all other treatment milieus)
- Objective Testing
- Functional Outcome Testing
- Primary Functional Limitation Issue
- Primary Functional Goal
- Assessment (Summarizing all previously identified information)
- Treatment Compliance
- Short Term Goals
- Long Term Goals
- Plan of Care (Including Discharge Planning)

☐ 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