



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
- Imaging/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