PhysMetrics

OCCUPATIONAL THERAPY - REHABILITATION
PRETREATMENT CERTIFICATION FORM

Patient Name: _____ DOB: _____ Age: _____ Sex: ☐ M ☐ F

Insurance ID #: _____ Occupation: _____

Insurance Plan/Employer: _____

Treating Provider's Name: _____ Phone: _____ Fax: _____

Clinic/Facility Name & Location (If applicable): _____

Treatment for Accident/Injury: ☐ Yes ☐ No If Yes, date occurred: _____ Type: ☐ Auto ☐ Work ☐ Other

Date of Onset: _____ First Visit Date: _____ Most Recent Visit Date: _____ # of visits current episode: ___

Has this patient had <u>previous</u> occupational therapy treatment for the <u>same</u> <u>condition</u> in past 12 months: ☐ Yes ☐ No

Response to Care: ☐ Good ☐ Fair ☐ Poor # of visits in past 12 months: ___ Prior Treatment Date Discharge: _____

Reason for Discharge (If known): _____

The following documents <u>must</u> be submitted with this form for consideration.

Attachment #1 (Required) - Valid Prescription

- Diagnosis (ICD-10) - Please List:
- Frequency & duration
- Prescribing physician's signature and date signed

Attachment #2 (Required) - Occupational Therapy Evaluation(s) ***Documents must include the clinical information listed below.***

- History of Condition (and/or Baseline)
- Prior Level of Functioning
- Imagining/Op/Referring Physicians Report Summation (If Applicable)
- Objective Testing
- Functional Outcome Testing (<u>Completed & Calculated</u>)
- Primary Functional Limitation Issue
- Primary Functional Goal
- Assessment (Summarizing all previously identified information)
- Short- and Long- Term Goals
- Treatment Progress
- Plan of Care

Attachment #3 (Optional) - Other (please describe): _____

Requested CPT code(s): _____

Requested Visit Frequency/Duration: _____

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

My signature below confirms the information provided is accurate and I am providing the requested services.

Treating Provider Signature:_____ Date: _____