PhysMetrics

PHYSICAL THERAPY - HABILITATIVE
PRETREATMENT CERTIFICATION FORM

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

Parent/Caregiver Name(s): ______________________________ School (if applicable): ___________________________

Insurance ID #: _______________________ Insurance Plan/Employer: ____

Treating Provider's Name: ___________________________________ Phone: ______________ Fax: _______________

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

First Visit Date: ____________ Most Recent Visit Date: ____________ # of visits current episode: _____________

Has this patient had previous physical therapy treatment for the same condition 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 and treatment information must 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) - Physical Therapy Evaluation(s) ***Documents must include the clinical information listed below***

- Baseline and/or History of Condition
- Coordination of Care (include care provided by all specialties in all other treatment milieus)
- Objective Testing
- Functional Outcome Testing (Completed & Calculated)
- Primary Functional Limitation Issue
- Assessment (summarizing all previously identified information)
- Treatment Compliance
- 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:** ______________________