

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 previous physical therapy treatment for the same condition in past 12 months: Yes NoResponse to Care: Good Fair Poor # of visits in past 12 months: _____ Prior Treatment Date Discharge: _____

Reason for Discharge (If known): _____

The following documents 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.

- History of Condition (and/or Baseline)
- Prior Level of Functioning
- Imaging/Op/Referring Physicians Report Summation (If Applicable)
- Objective Testing
- Functional Outcome Testing (Completed & Calculated)
- 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: _____