MANAGED HEALTHCARE NORTHWEST, INC.
422 E. BURNSIDE, SUITE 215, PO BOX 4629, PORTLAND, OREGON 97208-4629
(503) 413-5800 FAX (503) 413-5801

CAREMARK COMP PHYSICAL MEDICINE PRECERTIFICATION- FORM 1

(Chiropractic, Osteopathic Manipulation, PT, OT [functional], Hand Therapy)

Date:		**Attending Physician:**	
Patient:		**Evaluation Date:**	
DOI:		**# of Treatments Your Office To Date:**	
Claim #:		**# of Treatments Last Certification:**	
Insurance		**# of Missed Appointments Last Cert:**	

Diagnosis	***ICD-9 Code:***

Treatment Dates For This Pre-Certification:

From: _____ To: _____

Subjective Reports: _____

Pain Scale**: /10 or NA** Disability rating: _____**%**

Disability scale used: ☐ Modified Oswestry Disability Questionnaire ☐ TAOS/Care Connections ☐ Optimal ☐ DASH

Current Work Status:			***Recommendations for RTW:***
☐ Regular	☐ Modified	☐ Not Working	☐ Regular ☐ Modified ___ Hrs./Day ___Days/Wk.

Strength Capacities	***Previous:***	***Current:***
Level Lift	#	#
Weight/carry		
Waist Floor		
Overhead		
Push		
Pull		

Job Requirements / Functions:

Muscle Strength	***Previous:***	***Current:***

Functional Limitations:

ROM Measurements	***Previous:***	***Current:***

Measurable / Functional Goals:	***Treatment Plan:***	***CPT Code:***

Proposed Treatment Plan: **Frequency: _____ X / week X _____ Weeks**

Comments / Justification for Further Care:

TREATING THERAPIST/PROVIDER MUST FILL OUT REQUEST FORM AND FAX BACK TO (503) 413-5864.

NO AUTHORIZATION CAN BE GIVEN UNLESS ALL OF THE NECESSARY INFORMATION IS PROVIDED

PLEASE BE SURE TO INCLUDE EVALUATION, CHART NOTES, PROGRESS NOTES FOR THE LAST CERTIFICATION PERIOD, AND A CURRENT PHYSICIAN REFERRAL.

Therapist Signature/License type: _____ Printed name: _____

Facility:_____ Phone: _____ Fax: _____

Tax I.D.: _____