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

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:

☐ Regular ☐ Modified ☐ Not Working

Recommendations for RTW:

☐ Regular ☐ Modified

___ Hrs./Day ___Days/Wk.

Job Requirements / Functions:

Functional Limitations:

Measurable / Functional Goals:

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

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

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

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.: _____