



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 2 (Acupuncture, Massage, Speech-Language Pathology, OT [cognitive], Vision Therapy, Pain Program)

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: _____ _____
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Treatment Dates For This Pre-Certification: From: _____ To: _____
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Subjective Reports: _____

Pain Scale: / 10 or NA

Current Functional Limitations: _____

Progress During Last Certification Period: _____

Measurable / Functional Goals This Certification Period:	Treatment Plan:	CPT Code:

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

Comments / Justification for Further Treatment: _____ _____

**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.**

SIGNATURE TREATING THERAPIST / PROVIDER: _____ PRINT NAME / CREDENTIALS: _____

FACILITY: _____ PHONE: _____ Fax: _____ Tax I.D.: _____