



# 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)

*Precertification required after the initial 60 days duration of physical medicine or 20 visits, whichever comes first, and for every 4 weeks thereafter.*

**DO NOT REQUEST MORE THAN 4 WEEKS DURATION PER REQUEST**

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

<u>Diagnosis</u>	<u>Current ICD-CM Code</u>	Treatment Dates For This Pre-Certification: From: _____ To: _____

Subjective Reports: \_\_\_\_\_

Pain Scale: /10 or NA

<u>Current Work Status:</u>	<u>Recommendations for RTW:</u>	<u>Strength Capacities:</u>	<u>Previous:</u>	<u>Current:</u>
		Level Lift/Carry	#	#
		Overhead		
		Push		
		Pull		

<u>Job Requirements/Functions:</u>	<u>Muscle Strength:</u>	<u>Previous:</u>	<u>Current:</u>

<u>Functional Limitations:</u>	<u>ROM Measurements:</u>	<u>Previous:</u>	<u>Current:</u>

<u>Goals for This Next Certification Period:</u>	<u>Treatment Plan:</u>	<u>CPT Codes:</u>

**Proposed Treatment Plan:** Frequency: \_\_\_\_\_ X / week X \_\_\_\_\_ Weeks

<u>Comments / Justification for Further Care:</u>

**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 ID: \_\_\_\_\_