



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

*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: _____

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

Subjective Reports:

Pain Scale: ____/10 or ____ NA

Current Functional Limitations:

Progress During the 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.: _____