



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: Beginning: _____ For: <u>4 Weeks</u>
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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>
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<u>Goals for This Next Certification Period:</u>	<u>Treatment Plan:</u>	<u>CPT Codes:</u>
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Proposed Treatment Plan: Frequency: _____ X / week X _____ Weeks (Not to exceed 4 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 ID: _____