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 30 days duration of physical medicine or 12 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:**
		Beginning: _____ For: 4 Weeks

Subjective Reports:

Pain Scale: /10 or ____ NA

Current Work Status:	***Recommendations for RTW:***	***Strength Capacities:***	***Previous:***	***Current:***
		Level Lift/Carry	#	#
		Overhead		
		Push		
Job Requirements/Functions:		**Pull**		
		Muscle Strength:	***Previous:***	***Current:***
Functional Limitations:		***ROM Measurements:***	***Previous:***	***Current:***
Goals for This Next Certification Period:		***Treatment Plan:***	***CPT Codes:***	

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: _____