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 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 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 (Not to exceed 4 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.: _____