Healthways WholeHealth Networks
Rapid Response System (RRS)

HEALTHWAYS

:

Preauthorization Request for Physical/Occupational Therapy or Physical Medicine

Patient Name: _____ **Provider/Facility:** _____

Patient ID: _____ **Location:** _____

Submitted by: _____ **Date Submitted (MM/DD/YYYY):** _____ / _____ / _____

1.	Do you have a referral from a healthcare provider for treating this patient?	☐ yes ☐ no
2.	What is the requested Start Date for this authorization?	☐☐ / ☐☐ / ☐☐☐☐
3.	Is this authorization request for a new episode or continuation of care?	☐ new ☐ continuation
4.	Is this condition new, recurring or chronic?	☐ new ☐ recurring ☐ chronic
5.	What type of injury or condition is this request related to? [check all that apply]	☐ work ☐ auto ☐ other injury ☐ post surgery ☐ none
6.	How long has the patient had this condition?	☐ < 1mo ☐ 1-3 mo ☐ > 3 mo
7.	What is the Initial Date you began treating this patient for this episode of care?	☐☐ / ☐☐ / ☐☐☐☐
8.	Have you or anyone in your facility, provided treatment to this patient within the past 6 months for any condition?	☐ yes ☐ no ☐ Unknown
9.	How many visits are being requested (including evaluation)?	☐☐ visits
10.	How many weeks will it take to complete the requested visits?	☐☐ weeks
11.	What is the primary Diagnosis Code for this episode?	
12.	Enter the secondary Diagnosis Code, if applicable.	
13.	Indicate the body region(s) involved (you may check more than one).	☐ UE ☐ LE ☐ L/S Spine ☐ C/T Spine ☐ Hand/Wrist ☐ Other
14.	Patient's most recent score for Patient Specific Functional Scale?	☐☐.☐ on a scale of 00 to 10
15.	What is the patient's average rating of pain over the past 2 weeks?	☐☐ on a scale of 0 to 10 (10 = severe)
16.	Does the patient have a history of pain for > 3 months?	☐ yes ☐ no
17.	Does the patient currently use and/or abuse the following?	☐ tobacco ☐ alcohol
18.	Is the patient currently taking any opioids?	☐ yes ☐ no
19.	Is the patient overweight or obese (BMI ≥25)?	☐ yes ☐ no
20.	Does the patient perform moderately intense exercise 3 times per week?	☐ yes ☐ no
21.	Do you feel the patient is confident in their ability to overcome their problem?	☐ yes ☐ no
22.	Does the patient currently have significant issues with depression or anxiety?	☐ yes ☐ no
23.	Are there any factors that limit effective communication with the patient?	☐ yes ☐ no
24.	Does the patient currently have Diabetes?	☐ yes ☐ no
25.	Does the patient currently have a Neurological Condition of the CNS?	☐ yes ☐ no
26.	Does the patient currently have a Cardiovascular Condition?	☐ yes ☐ no
27.	Does the patient currently have Cancer?	☐ yes ☐ no
28.	Does the patient currently have Chronic Lung Disease?	☐ yes ☐ no

Verify the information is correct, submit the authorization request, and file with the patient's records. When your request is authorized, the approved visits must be delivered within the pre-authorized time limits. Please record the information below.

Auth Reference #: _____ Visits Approved: _____ Approved Through: _____/_____/_____

You will receive a fax confirmation of the prescreening results. The RRS pre-screening will either approve or pend your authorization request. If additional information is required, you will receive a fax request indicating the specific clinical information to submit for utilization review. Use the request form, which is bar-coded for this specific patient, as a cover sheet when faxing clinical records and any other relevant clinical information that will support the present diagnosis(es) and treatment plan to: **1-888-492-1025.**