



WholeHealth Networks, Inc.

Preauthorization Request for Manipulative Therapy Services

Patient Name: _____ Provider/Facility: _____
 Patient ID: _____ Location: _____
 Submitted by: _____ Date Submitted (MM/DD/YYYY): ____ / ____ / ____

1.	What is the requested Start Date for this authorization?	<input type="text"/> / <input type="text"/> / <input type="text"/>
2.	Is this authorization request for a new episode or continuation of care?	<input type="checkbox"/> new <input type="checkbox"/> continuation
3.	Is this condition new, recurring, or chronic?	<input type="checkbox"/> new <input type="checkbox"/> recurring <input type="checkbox"/> chronic
4.	What type of injury or condition is this request related to?	<input type="checkbox"/> work <input type="checkbox"/> auto <input type="checkbox"/> other injury <input type="checkbox"/> post surgery <input type="checkbox"/> none
5.	How long has the patient had this condition?	<input type="checkbox"/> < 1mo <input type="checkbox"/> 1-3 mo <input type="checkbox"/> > 3 mo
6.	What is the Initial Date you began treating this patient for this episode of care?	<input type="text"/> / <input type="text"/> / <input type="text"/>
7.	How many treatments (visits) have you, or anyone in your facility, provided to this patient over the past 6 months for <u>any</u> diagnosis?	<input type="text"/> visits
8.	Is this patient's MD/DO currently co-treating the condition?	<input type="checkbox"/> yes <input type="checkbox"/> no
9.	How many visits are being requested for the current phase of care (including evaluation)?	<input type="text"/> visits
10.	How many weeks will it take to complete the visits?	<input type="text"/> weeks
11.	What is the first (primary) Diagnosis Code?	
12.	What is the second Diagnosis Code?	
13.	What is the third Diagnosis Code?	
14.	What is the patient's average rating of pain over the past 2 weeks?	<input type="text"/> on a scale of 0 to 10 (10 = severe)
15.	Does the patient have a history of pain for > 3 months?	<input type="checkbox"/> yes <input type="checkbox"/> no
16.	Patient's most recent score for Patient Specific Functional Scale?	<input type="text"/> on a scale of 00 to 10
17.	Does the patient routinely exercise with moderate intensity \geq 3 times per week?	<input type="checkbox"/> yes <input type="checkbox"/> no
18.	Does the patient smoke or use tobacco products?	<input type="checkbox"/> yes <input type="checkbox"/> no
19.	Does the patient have a history of Diabetes?	<input type="checkbox"/> yes <input type="checkbox"/> no
20.	Does the patient have a history of Stroke?	<input type="checkbox"/> yes <input type="checkbox"/> no
21.	Does the patient have a history of Cancer?	<input type="checkbox"/> yes <input type="checkbox"/> no
22.	Is the patient overweight or obese (BMI \geq 25)?	<input type="checkbox"/> yes <input type="checkbox"/> no
23.	Does the patient have a history of depression or anxiety?	<input type="checkbox"/> yes <input type="checkbox"/> no
24.	Are there any factors that limit effective communication with the patient?	<input type="checkbox"/> yes <input type="checkbox"/> no

Verify the information is correct, submit the authorization request via the *Authorization Submission* transaction in Navinet, and file with the patient's records.

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**.

For a complete list of services requiring authorization, please access the Physical Medicine Management Program Administrative Guide on the Highmark Provider Resource Center under Care Management Programs → Physical Medicine Management Program.