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?	M M / D D / Y Y Y Y
2.	Is this authorization request for a new episode or continuation of care?	X new X continuation
3.	Is this condition new, recurring, or chronic?	X new X recurring X chronic
4.	What type of injury or condition is this request related to?	X work X auto X other injury X post surgery X none
5.	How long has the patient had this condition?	X < 1mo X 1-3 mo X > 3 mo
6.	What is the Initial Date you began treating this patient for this episode of care?	M M / D D / Y Y Y Y
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?	# # visits
8.	Is this patient's MD/DO currently co-treating the condition?	X yes X no
9.	How many visits are being requested for the current phase of care (including evaluation)?	# # visits
10.	How many weeks will it take to complete the visits?	# # 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?	# # on a scale of 0 to 10 (10 = severe)
15.	Does the patient have a history of pain for > 3 months?	X yes X no
16.	Patient's most recent score for Patient Specific Functional Scale?	# # . # on a scale of 00 to 10
17.	Does the patient routinely exercise with moderate intensity <u>≥</u> 3 times per week?	X yes X no
18.	Does the patient smoke or use tobacco products?	X yes X no
19.	Does the patient have a history of Diabetes?	X yes X no
20.	Does the patient have a history of Stroke?	X yes X no
21.	Does the patient have a history of Cancer?	X yes X no
22.	Is the patient overweight or obese (BMI <u>≥</u>25)?	X yes X no
23.	Does the patient currently have significant problems with depression or anxiety?	X yes X no
24.	Are there any factors that limit effective communication with the patient?	X yes X 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.**