



WholeHealth Networks, Inc.

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