**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? | ☐ 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.**