

Occupational Therapy Authorization Form



www.tuftshealthplan.com/providers
 Provider Services - 888-884-2404
 Precertification Department (FAX) - 617-972-9409

Ongoing coverage beyond 60 days from initial treatment visit. Fax to the Precertification Department (617-972-9409)

1. Member Name:		2. DOB:		3. DOI		4. Date of Report:					
5. Member ID#:			6. Dx:			7. ICD-9:					
8. Facility Name:			9. Provider ID:			10. Facility Phone #:		11. Facility Fax:			
12. Previous Rx for this Dx? Yes <input type="checkbox"/> No <input type="checkbox"/>			13. Any other Dx? Yes <input type="checkbox"/> No <input type="checkbox"/>		14. Total Visits Since Start of Care:		15. # of Visits Requested:				
16. Start of Care					17. Est D/C Date:						
18. Initial/Previous Clinical Status				19. Current Clinical Status				20. Current Functional Status			
A. Pain Intensity: 0/10-10/10: _____ B. ROM: _____ C. Strength: _____ D. Alignment: _____ E. Ambulatory Status/Balance: _____ F. Sensory/Reflexes: _____				A. Pain Intensity: 0/10-10/10: _____ B. ROM: _____ C. Strength: _____ D. Alignment: _____ E. Ambulatory Status/Balance: _____ F. Sensory/Reflexes: _____				Please use this scale for 1-4 (1: Fully Able 75-100%, 2: 50-75%, 3: 25-50%, 4: 0-25%) A. Personal Care 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> N/A <input type="checkbox"/> B. Household Mobility 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> N/A <input type="checkbox"/> C. Community Mobility 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> N/A <input type="checkbox"/> D. Sitting Tolerance 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> N/A <input type="checkbox"/> E. Stair Climbing 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> N/A <input type="checkbox"/> F. Driving 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> N/A <input type="checkbox"/> G. Household Chores 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> N/A <input type="checkbox"/> H. Lift Objects 1-10 lbs 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> N/A <input type="checkbox"/> I. Lift Objects >20 lbs 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> N/A <input type="checkbox"/> J. Work Tolerance 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> N/A <input type="checkbox"/> K. Sports/Recreation 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> N/A <input type="checkbox"/>			
Comments: _____											
21. Current Treatment Plan				22. Current Clinical Goals				23. Functional Outcomes			
Provider Name: _____					Provider #: _____						
Requested By: _____					Signature: _____						