

Physical Therapy Authorization Form



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

Ongoing coverage beyond initial evaluation and 8 visits. Fax to the Precertification Department (617-972-9409).

1. Member Name:		2. DOB:		3. DOI		4. Date of Report:		
5. Member ID#:			6. ICD-9:			7. Diagnosis:		
8. Facility Name:			9. Tufts Health Plan Facility ID #:		10. Facility Phone #:		11. Facility Fax:	
12. Previous Rx for this Dx? Yes <input type="checkbox"/> No <input type="checkbox"/>			13. # of Visits Requested <input type="checkbox"/>		14. Initial Treatment Date:		15. Estimated D/C Date:	
16. Any Other Diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/>			17. Frequency of PT Visits:		18. Total Visits Since Initial Treatment 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"/>		
Is the Member compliant with their Home Exercise Program (HEP)? Yes <input type="checkbox"/> No <input type="checkbox"/>								
Comments: _____								
21. Current Treatment Plan			22. Current Clinical Goals			23. Functional Outcomes		
Provider Name: _____					Provider #: _____			
Requested By: _____					Signature: _____			