OUTPATIENT THERAPY PROGRESS REPORT

This form should be filled out and submitted by the physical therapist when it is determined that the member will require additional visits to meet his/her goals. Please submit this form along with a copy of the referring physician's prescription for therapy. All forms can be submitted via fax to 1-855-231-8664.

MEMBER INFORMATION

LAST NAME _____ FIRST NAME _____
MEMBER ID _____ DATE OF BIRTH _____ SEX ____ M ____ F

PROVIDER INFORMATION

PROVIDER NAME _____ PROVIDER ID _____
PHONE NUMBER (_____) _____ FAX NUMBER (_____) _____
CONTACT NAME _____ EXTENSION _____

PRIMARY DIAGNOSIS AND CURRENT PAIN RATING

DIAGNOSIS (ICD-9) CODE _____ DESCRIPTION _____
CURRENT PAIN RATING _____ / 10 CHANGE IN SYMPTOMS (circle one) Improved Worsened Unchanged
NEW SYMPTOMS REPORTED _____

FUNCTIONAL ASSESSMENT AND PROGRESSION TO DATE

TESTS/MEASURES

_____
_____

FUNCTIONAL LIMITATIONS (circle one): Improved Worsened Unchanged
Describe if improved or worsened _____

SHORT-TERM GOALS (circle one): Completely met Partially met Not met

THERAPY ATTENDANCE (circle one): Consistent Inconsistent HEP COMPLIANCE (circle one): Consistent Inconsistent

PREVIOUS AUTHORIZATION WAS FOR _____VISITS. MEMBER HAS COMPLETED _____ OF THOSE VISITS.

UPDATED PROGNOSIS AND PLAN OF CARE

PROGNOSIS (Potential to reach maximum functional level — circle one): Excellent Good Fair Poor
CONTINUE PHYSICAL THERAPY _____ times per week for _____ (number of weeks)
CONTINUE OCCUPATIONAL THERAPY _____ times per week for _____ (number of weeks)

LONG-TERM GOALS — EXPECTED NUMBER OF VISITS TO ACHIEVE: _____
Increase ROM by _____ degrees
Increase strength by _____ grade(s)
Decrease pain to _____ / 10 Independent HEP
Restore 100% of prior level of function

THERAPY REQUEST

Based upon my updated assessment performed, I am requesting authorization for _____ visits over _____ days.

Therapist's Signature _____ Date _____