

Voluntary Prior Approval Process

1. You sign this Voluntary Prior Approval Agreement Form upon your initial visit to indicate that you are opting to obtain prior approval for non-participating physical therapy or occupational therapy services that you understand the process, that you agree to the procedures described here and that you authorize your non-participating provider to submit information on your behalf.
2. You ask your non-participating provider to submit a completed one page Patient Summary Form, a one page Patient Health Questionnaire (PHQ), along with this signed Voluntary Prior Approval Agreement Form directly to OptumHealth (fax to 1-866-695-6923). You or your non-participating provider can obtain a copy of the Patient Summary and PHQ forms by calling OptumHealth at 1-877-369-7564 or by visiting OptumHealth's Web site at www.myoptumhealthphysicalhealth.com.
3. OptumHealth will respond to both you and your provider for each Patient Summary Form received, indicating the time frame and services that have been approved or that the services have not been approved.
 - a. If the services are approved, you are responsible only for out-of-network cost shares (e.g., deductible and coinsurance amounts).
 - b. If the services are not approved and you choose to receive care, you will be responsible for the cost in full. You may appeal that decision by following the procedures attached with the response or as described in your Certificate of Coverage.
4. If your treating provider believes that you need care beyond the approved number of services and/or time frame provided, he/she should submit a new updated Patient Summary Form, including asking you to complete a new Patient Health Questionnaire to assess your progress. *If the new forms are not submitted, the claims will be reviewed retrospectively as described.*
5. If you change non-participating therapy providers and wish to continue to use the Voluntary Prior Approval process, the new provider should submit your new **Voluntary Prior Approval Agreement Form** along with a newly completed Patient Summary Form and Patient Health Questionnaire.

Submission of this form indicates that you understand the Voluntary Prior Approval process; you agree to the procedures outlined in this letter and that you authorize your non-participating provider to submit a Patient Summary Form/PHQ on your behalf.

Treating Practitioner's Name: Tamar Amitay

Clinic Name (if available): Thrive Integrated Physical Therapy, PC

Treating Practitioner's Street Address: 611 Broadway #503

Treating Practitioner's City, State, ZIP: New York, NY 10012

Treating Practitioner's Tax Identification Number: 75-3122641

Treating Practitioner's Phone Number: 212-254-7750

Member's Name: _____ Member's DOB: _____

Member's ID Number: _____

Member/Guardian Signature: _____ Date: _____

Patient Summary Form

PSF-750 (Rev.2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Female	<input type="text"/>
Patient name	Last	First	MI	<input type="radio"/> Male	Patient date of birth
<input type="text"/>			<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient address			City	State	Zip code
<input type="text"/>		<input type="text"/>		<input type="text"/>	
Patient Insurance ID#		Health plan		Group number	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
Referring physician (if applicable)			Date referral issued (if applicable)		Referral number (if applicable)
<input type="text"/>			<input type="text"/>		<input type="text"/>

Provider Information

<input type="text"/>			<input type="text"/>		
1. Name of the billing provider or facility (as it will appear on the claim form)			2. Federal tax ID(TIN) of entity in box #1		
<input type="text"/>			<input type="text"/>		
3. Name and credentials of the individual performing the service(s)			4. Alternate name (if any) of entity in box #1		
<input type="text"/>			<input type="text"/>		
5. NPI of entity in box #1			6. Phone number		
<input type="text"/>			<input type="text"/>		
7. Address of the billing provider or facility indicated in box #1			8. City		9. State
<input type="text"/>			<input type="text"/>		<input type="text"/>
					10. Zip code
					<input type="text"/>

Provider Completes This Section:

Date you want THIS submission to begin:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Patient Type

- (1) New to your office
- (2) Est'd, new injury
- (3) Est'd, new episode
- (4) Est'd, continuing care

Cause of Current Episode

- (1) Traumatic
- (2) Unspecified
- (3) Repetitive
- (4) Post-surgical
- (5) Work related
- (6) Motor vehicle

Date of Surgery

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Type of Surgery

- (1) ACL Reconstruction
- (2) Rotator Cuff/Labral Repair
- (3) Tendon Repair
- (4) Spinal Fusion
- (5) Joint Replacement
- (6) Other _____

Diagnosis (ICD code)

Please ensure all digits are entered accurately

1°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Nature of Condition

- (1) Initial onset (within last 3 months)
- (2) Recurrent (multiple episodes of < 3 months)
- (3) Chronic (continuous duration > 3 months)

DC ONLY

Anticipated CMT Level

- 98940 98942
- 98941 98943

Current Functional Measure Score

Neck Index	<input type="text"/>	DASH	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Back Index	<input type="text"/>	LEFS	<input type="text"/>	<input type="text"/>	<input type="text"/>	(other) <input type="text"/>

Patient Completes This Section:

Symptoms began on:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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(Please fill in selections completely)

1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

- Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
- Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

4. How often do you experience your symptoms?

- (1) Constantly (76%-100% of the time)
- (2) Frequently (51%-75% of the time)
- (3) Occasionally (26% - 50% of the time)
- (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

- (1) Not at all
- (2) A little bit
- (3) Moderately
- (4) Quite a bit
- (5) Extremely

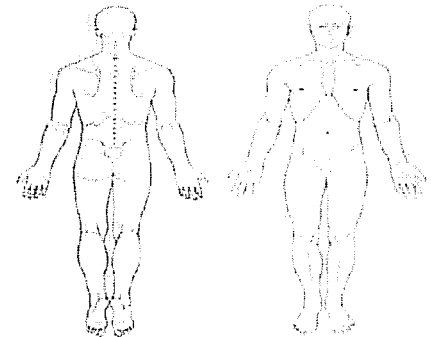
6. How is your condition changing, since care began at this facility?

- (0) N/A — This is the initial visit
- (1) Much worse
- (2) Worse
- (3) A little worse
- (4) No change
- (5) A little better
- (6) Better
- (7) Much better

7. In general, would you say your overall health right now is...

- (1) Excellent
- (2) Very good
- (3) Good
- (4) Fair
- (5) Poor

Indicate where you have pain or other symptoms:



Patient Signature: X

Date: _____