Healthways WholeHealth Networks
Rapid Response System (RRS)

HEALTHWAYS

Preauthorization Request for Physical / Occupational Therapy

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?	M M / D D / Y Y Y Y
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?	☒ < 1 mo. ☒ 1-3 mo. ☒ > 3 mo.
7.	What is the Initial Date you began treating this patient for this episode of care?	M M / D D / Y Y Y Y
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 ICD-9 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 # L/S Spine # Hand/Wrist # LE # C/T Spine # 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.**