Healthways WholeHealth Networks
Rapid Response System (RRS)

HEALTHWAYS

Preauthorization Request for Manipulation Services

Patient Name: ______________________________ **Provider/Facility:** ______________________________

Patient ID:______________________________ **Location:**______________________________

Submitted by: ______________________________ **Date Submitted (MM/DD/YYYY):** ____ / _____/ ___________

1.	What is the requested Start Date for this authorization?	☐☐ / ☐☐ / ☐☐☐☐
2.	Is this authorization request for a new episode or continuation of care?	☐ new ☐ continuation
3.	Is this condition new, recurring, or chronic?	☐ new ☐ chronic ☐ recurring
4.	What type of injury or condition is this request related to?	☐ work ☐ auto ☐ other injury ☐ post-surgery ☐ none
5.	How long has the patient had this condition?	☐ < 1 mo ☐ 1-3 mo ☐ > 3 mo
6.	What is the Initial Date you began treating this patient for this episode of care?	☐☐ / ☐☐ / ☐☐☐☐
7.	How many treatments (visits) have you, or anyone in your facility, provided to this patient over the past 6 months for <u>any</u> diagnosis?	☐☐ visits
8.	Is this patient's MD/DO currently co-treating the condition?	☐ yes ☐ no
9.	How many visits are being requested for the current phase of care (including evaluation)?	☐☐ visits
10.	How many weeks will it take to complete the visits?	☐☐ weeks
11.	What is the first (primary) ICD-9 Diagnosis Code?	☐☐☐ . ☐☐
12.	What is the second ICD-9 Diagnosis Code?	☐☐☐ . ☐☐
13.	What is the third ICD-9 Diagnosis Code?	☐☐☐ . ☐☐
14.	What is the patient's average rating of pain over the past 2 weeks?	☐☐ on a scale of 0 to 10 (10 = severe)
15.	Does the patient have a history of pain for > 3 months?	☐ yes ☐ no
16.	Patient's most recent score for Patient Specific Functional Scale?	☐☐ . ☐ on a scale of 0.0 to 10.0
17.	Does the patient routinely exercise with moderate intensity ≥ 3 times per week?	☐ yes ☐ no
18.	Does the patient smoke or use tobacco products?	☐ yes ☐ no
19.	Does the patient have a history of Diabetes?	☐ yes ☐ no
20.	Does the patient have a history of Stroke?	☐ yes ☐ no
21.	Does the patient have a history of Cancer?	☐ yes ☐ no
22.	Is the patient overweight or obese (BMI ≥25)?	☐ yes ☐ no
23.	Does the patient currently have significant problems with depression or anxiety?	☐ yes ☐ no
24.	Are there any factors that limit effective communication with the patient?	☐ 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.**