

Patient Summary Form

PSF-750 (Rev: 7/1/2015)

Instructions

Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

Patient Information

<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"/>	<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"/>																				
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:12.5%; text-align:center;">1</td> <td style="width:12.5%; text-align:center;">MD/DO</td> <td style="width:12.5%; text-align:center;">2</td> <td style="width:12.5%; text-align:center;">DC</td> <td style="width:12.5%; text-align:center;">3</td> <td style="width:12.5%; text-align:center;">PT</td> <td style="width:12.5%; text-align:center;">4</td> <td style="width:12.5%; text-align:center;">OT</td> <td style="width:12.5%; text-align:center;">5</td> <td style="width:12.5%; text-align:center;">Both PT and OT</td> <td style="width:12.5%; text-align:center;">6</td> <td style="width:12.5%; text-align:center;">Home Care</td> <td style="width:12.5%; text-align:center;">7</td> <td style="width:12.5%; text-align:center;">ATC</td> <td style="width:12.5%; text-align:center;">8</td> <td style="width:12.5%; text-align:center;">MT</td> <td style="width:12.5%; text-align:center;">9</td> <td style="width:12.5%; text-align:center;">Other</td> <td style="width:12.5%; text-align:center;">_____</td> </tr> </table>				1	MD/DO	2	DC	3	PT	4	OT	5	Both PT and OT	6	Home Care	7	ATC	8	MT	9	Other	_____
1	MD/DO	2	DC	3	PT	4	OT	5	Both PT and OT	6	Home Care	7	ATC	8	MT	9	Other	_____				
3. Name and credentials of the individual performing the service(s)																						
<input type="text"/>																						
4. Alternate name (if any) of entity in box #1		5. NPI of entity in box #1																				
<input type="text"/>		<input type="text"/>																				
7. Address of the billing provider or facility indicated in box #1		8. City																				
<input type="text"/>		<input type="text"/>																				
9. State		10. Zip code																				
<input type="text"/>		<input type="text"/>																				

Provider Completes This Section:

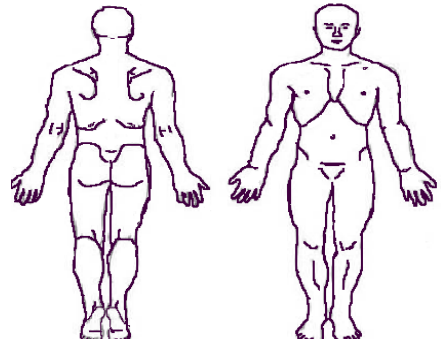
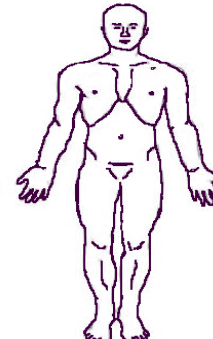
<p>Date you want THIS submission to begin:</p> <input type="text"/>	<p>Cause of Current Episode</p> <p> <input type="radio"/> (1) Traumatic <input type="radio"/> (4) Post-surgical <input type="radio"/> (2) Unspecified <input type="radio"/> (5) Work related <input type="radio"/> (3) Repetitive <input type="radio"/> (6) Motor vehicle </p>	<p>Date of Surgery</p> <input type="text"/>	<p>Diagnosis (ICD codes) Please ensure all digits are entered accurately</p> <p>1° <input type="text"/></p> <p>2° <input type="text"/></p> <p>3° <input type="text"/></p> <p>4° <input type="text"/></p>
<p>Patient Type</p> <p> <input type="radio"/> (1) New to your office <input type="radio"/> (2) Est'd, new injury <input type="radio"/> (3) Est'd, new episode <input type="radio"/> (4) Est'd, continuing care </p>	<p>Type of Surgery</p> <p> <input type="radio"/> (1) ACL Reconstruction <input type="radio"/> (2) Rotator Cuff/Labral Repair <input type="radio"/> (3) Tendon Repair <input type="radio"/> (4) Spinal Fusion <input type="radio"/> (5) Joint Replacement <input type="radio"/> (6) Other _____ </p>		
<p>Nature of Condition</p> <p> <input type="radio"/> (1) Initial onset (within last 3 months) <input type="radio"/> (2) Recurrent (multiple episodes of < 3 months) <input type="radio"/> (3) Chronic (continuous duration > 3 months) </p>	<p>DC ONLY</p> <p>Anticipated CMT Level</p> <p> <input type="radio"/> 98940 <input type="radio"/> 98942 <input type="radio"/> 98941 <input type="radio"/> 98943 </p>	<p>Current Functional Measure Score</p> <p>Neck Index <input type="text"/> DASH <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Back Index <input type="text"/> LEFS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (other FOM)</p>	

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:

- Briefly describe your symptoms: _____
- How did your symptoms start? _____
- 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
- 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)
- 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
- 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
- In general, would you say your overall health right now is...

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

Patient Signature: X **Date:** _____