

Patient Summary Form

PSF-750 (Rev:12/11/2013)

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"/>	
<input type="checkbox"/> 1 MD/DO <input type="checkbox"/> 2 DC <input type="checkbox"/> 3 PT <input type="checkbox"/> 4 OT <input type="checkbox"/> 5 Both PT and OT <input type="checkbox"/> 6 Home Care <input type="checkbox"/> 7 ATC <input type="checkbox"/> 8 MT <input type="checkbox"/> 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"/>	
6. Phone number		<input type="text"/>	
<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 code) 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>Current Functional Measure Score</p> <p>Neck Index <input type="text"/> DASH <input type="text"/></p> <p>Back Index <input type="text"/> LEFS <input type="text"/> (other) <input type="text"/></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>	

Patient Completes This Section:

Symptoms began on:

(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

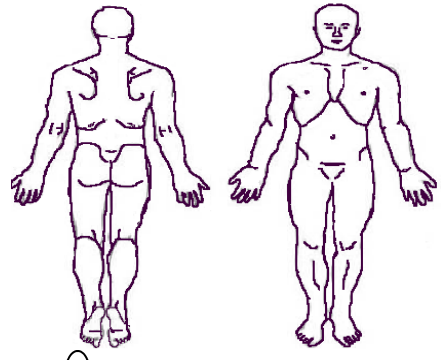
6. How is your condition changing, since care began at this facility?

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:** _____

The STarT Back Musculoskeletal Screening Tool

Patient name: _____ Date: _____

 Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1 My pain has spread at some time in the past 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2 In addition to my main pain, I have had pain elsewhere in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 In the last 2 weeks, I have only walked short distances because of my pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have dressed more slowly than usual because of my pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's really not safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 Worrying thoughts have been going through my mind a lot of the time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that my pain is terrible and that it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>
8 In general in the last 2 weeks, I have not enjoyed all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

 9. Overall, how **bothersome** has your pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	0	0	1	1



Patient Billing Acknowledgement Form Non-Covered Services**

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as supplies, vitamins, or durable medical equipment.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

**** Not for use in New Jersey**

P R O V I D E R	<p><u>Services to be provided:</u></p> <p><input type="checkbox"/> Supply _____ <input type="checkbox"/> DME _____</p> <p><input type="checkbox"/> Modalities/Procedures _____ <input type="checkbox"/> Other _____</p> <p>Time frame from _____ through _____</p> <p>Schedule/details _____</p> <p>Provider Signature: _____</p>
P A T I E N T	<p>I _____, acknowledge that I have been told <div style="text-align: center; font-size: small;">Patient Name – Printed or Typed</div> in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.</p> <p>Patient/Guardian Signature _____ Date _____</p>

Patient Billing Acknowledgement Form Maintenance/Elective Care**

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

If, during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.

**** Not for use in New Jersey**

P R O V I D E R	<p><u>Services to be provided are listed below:</u></p> <p><input type="checkbox"/> Chiropractic Manipulative Therapy _____ <input type="checkbox"/> In-Home Care _____</p> <p><input type="checkbox"/> Modalities/Procedures _____ <input type="checkbox"/> Other _____</p> <p>Time frame from _____ through _____</p> <p>Schedule/details _____</p> <p>Provider Signature: _____</p>
P A T I E N T	<p>I _____, acknowledge that I have been told <div style="text-align: center; font-size: small;">Patient Name – Printed or Typed</div> in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.</p> <p>Patient/Guardian Signature _____ Date _____</p> <p>_____</p>