

PT  OT  SLP  CHIRO

Initial  Extension

Patient Name: \_\_\_\_\_

Patient Social Security No.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Insured Social Security No.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Other Insurance: \_\_\_\_\_

MVA: \_\_\_\_\_

Primary  Secondary

Rehabilitation Practitioner Name: \_\_\_\_\_

Workers' Compensation: \_\_\_\_\_

Rehabilitation Practitioner Tax ID No.: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Rehabilitation Practitioner Telephone No.: ( ) \_\_\_\_\_ - \_\_\_\_\_

Physician's Telephone No.: \_\_\_\_\_

Provider Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

ICD-9 Code: \_\_\_\_\_

CPT Code: \_\_\_\_\_

Date of Onset/Injury: \_\_\_\_\_

Nature of Injury: \_\_\_\_\_

Work related? Y/N \_\_\_\_\_

Surgical Procedure (post operative): List the type: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Initial Evaluation Date: \_\_/\_\_/\_\_ Last Date of Service: \_\_/\_\_/\_\_ No. of Visits to Date: \_\_\_\_\_

Narrative Patient History (Chief Complaint):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Initial Objective Findings and Functional Status:

Present Objective Findings and Functional Status:


Number of Additional Visits Requested: \_\_\_\_ Physician's Name: \_\_\_\_\_ Concurrency: Y  N

Goals of Additional Treatment Plan: \_\_\_\_\_

For office use only: PREVIOUS Patient Pre-certification Yes <input type="checkbox"/> Number of visits ____; None <input type="checkbox"/> Total number of visits certified: _____ Start Date: __/__/__ End Date: __/__/__ Certification <input type="checkbox"/> Potential Non-Cert <input type="checkbox"/> REFERENCE NUMBER(S): _____ - _____ Coordinator Initials: _____
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Please fax the following to 301-545-5890: completed rehabilitation request form, progress notes, relevant clinical information. Please allow a 48-hour turnaround time for processing requests. Missing/incomplete information may delay processing of requests. For verification of benefits and eligibility please refer to the telephone number noted on the participant's health plan identification card.

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