

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
Patient address		City	State	Zip code
Patient insurance ID#	Health plan	Group number		
Referring physician (if applicable)	Date referral issued (if applicable)	Referral number (if applicable)		

Provider Information

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				
3. Name and credentials of the individual performing the service(s)					<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 _____				
4. Alternate name (if any) of entity in box #1			5. NPI of entity in box #1			6. Phone number			
7. Address of the billing provider or facility indicated in box #1					8. City		9. State		10. Zip code

Provider Completes This Section:

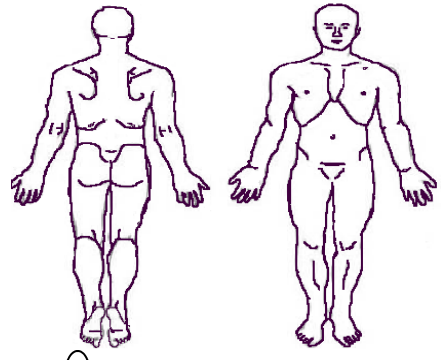
Date you want THIS submission to begin: <input type="text"/>	Cause of Current Episode <input type="radio"/> 1 Traumatic <input type="radio"/> 2 Unspecified <input type="radio"/> 3 Repetitive <input type="radio"/> 4 Post-surgical <input type="radio"/> 5 Work related <input type="radio"/> 6 Motor vehicle	Date of Surgery <input type="text"/>	Diagnosis (ICD codes) Please ensure all digits are entered accurately 1° <input type="text"/> 2° <input type="text"/> 3° <input type="text"/> 4° <input type="text"/>
Patient Type <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	1 Habilitative 2 Rehabilitative	Type of Surgery <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 _____	
Nature of Condition <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)	DC ONLY Anticipated CMT Level <input type="radio"/> 98940 <input type="radio"/> 98942 <input type="radio"/> 98941 <input type="radio"/> 98943	Current Functional Measure Score Neck Index <input type="text"/> DASH <input type="text"/> (other FOM) <input type="text"/> Back Index <input type="text"/> LEFS <input type="text"/>	

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	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10	worst pain
Past week:	no pain	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10	worst pain
- How often do you experience your symptoms?

<input type="radio"/> 1 Constantly (76%-100% of the time)	<input type="radio"/> 2 Frequently (51%-75% of the time)	<input type="radio"/> 3 Occasionally (26% - 50% of the time)	<input type="radio"/> 4 Intermittently (0%-25% of the time)
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- How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

<input type="radio"/> 1 Not at all	<input type="radio"/> 2 A little bit	<input type="radio"/> 3 Moderately	<input type="radio"/> 4 Quite a bit	<input type="radio"/> 5 Extremely
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- How is your condition changing, since care began at this facility?

<input type="radio"/> 0 N/A — This is the initial visit	<input type="radio"/> 1 Much worse	<input type="radio"/> 2 Worse	<input type="radio"/> 3 A little worse	<input type="radio"/> 4 No change	<input type="radio"/> 5 A little better	<input type="radio"/> 6 Better	<input type="radio"/> 7 Much better
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- In general, would you say your overall health right now is...

<input type="radio"/> 1 Excellent	<input type="radio"/> 2 Very good	<input type="radio"/> 3 Good	<input type="radio"/> 4 Fair	<input type="radio"/> 5 Poor
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Patient Signature: X Date: _____