

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<small>Patient name Last</small>	<small>First</small>	<small>MI</small>	<small>Female</small> <input type="radio"/> <small>Male</small> <input type="radio"/>
<input type="text"/>		<input type="text"/>	
<small>Patient address</small>		<small>City</small>	<small>State</small> <small>Zip code</small>
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<small>Patient Insurance ID#</small>	<small>Health plan</small>	<small>Group number</small>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<small>Referring physician (if applicable)</small>	<small>Date referral issued (if applicable)</small>	<small>Referral number (if applicable)</small>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

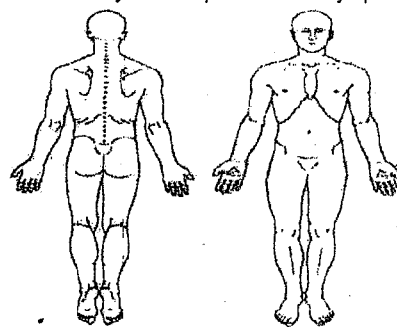
Provider Information

<input type="text"/>		<input type="text"/>	
<small>1. Name of the billing provider or facility (as it will appear on the claim form)</small>		<small>2. Federal tax ID(TIN) of entity in box #1</small>	
<input type="text"/>		<input type="text"/>	
<small>3. Name and credentials of the individual performing the service(s)</small>	<small>4. Alternate name (if any) of entity in box #1</small>	<small>5. NPI of entity in box #1</small>	<small>6. Phone number</small>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<small>7. Address of the billing provider or facility indicated in box #1</small>	<small>8. City</small>	<small>9. State</small>	<small>10. Zip code</small>
<input type="text"/>	<input type="text"/>	<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) <i>Please ensure all digits are entered accurately</i></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>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>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>Current Functional Measure Score</p> <p> Neck Index <input type="text"/> DASH <input type="text"/> <input type="text"/> <input type="text"/> Back Index <input type="text"/> LEFS <input type="text"/> <input type="text"/> (other) </p>	

Patient Completes This Section:

<p>Symptoms began on: <input type="text"/></p> <p>(Please fill in selections completely)</p> <p>1. Briefly describe your symptoms:</p> <hr/> <p>2. How did your symptoms start?</p> <hr/> <p>3. Average pain intensity:</p> <p>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</p> <p>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</p> <p>4. How often do you experience your symptoms?</p> <p> <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) </p> <p>5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)</p> <p> <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 </p> <p>6. How is your condition changing, since care began at this facility?</p> <p> <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 </p> <p>7. In general, would you say your overall health right now is...</p> <p> <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 </p>	<p>Indicate where you have pain or other symptoms:</p> 
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Patient Signature: X

Date: _____