Voluntary Prior Approval Process

- You sign this Voluntary Prior Approval Agreement Form upon your initial visit to indicate that you are
 opting to obtain prior approval for non-participating physical therapy or occupational therapy services
 that you understand the process, that you agree to the procedures described here and that you
 authorize your non-participating provider to submit information on your behalf.
- 2. You ask your non-participating provider to submit a completed one page <u>Patient Summary Form</u> along with this signed <u>Voluntary Prior Approval Agreement Form</u> directly to OptumHealth (fax to 1-866-695-6923). You or your non-participating provider can obtain a copy of the Patient Summary Form by calling OptumHealth at 1-877-369-7564 or by visiting OptumHealth's Web site at www.myoptumhealthphysicalhealth.com.
- OptumHealth will respond to both you and your provider for each Patient Summary Form received, indicating the time frame and services that have been approved or that the services have not been approved.
 - a. If the services are approved, you are responsible only for out-of-network cost shares (e.g., deductible and coinsurance amounts).
 - b. If the services are not approved and you choose to receive care, you will be responsible for the cost in full. You may appeal that decision by following the procedures attached with the response or as described in your Certificate of Coverage.
- 4. If your treating provider believes that you need care beyond the approved number of services and/or time frame provided, he/she should submit a new updated Patient Summary Form, including asking you to complete the Patient Section of the Patient Summary Form to assess your progress. If the new forms are not submitted, the claims will be reviewed retrospectively as described.
- 5. If you change non-participating therapy providers and wish to continue to use the Voluntary Prior Approval process, the new provider should submit your new **Voluntary Prior Approval Agreement Form** along with a newly completed Patient Summary Form.

Submission of this form indicates that you understand the Voluntary Prior Approval process; you agree to the procedures outlined in this letter and that you authorize your non-participating provider to submit a Patient Summary Form on your behalf.

Treating Practitioner's Name		
Clinic Name (if available):		
Treating Practitioner's Street Address:		
Treating Practitioner's City, State, ZIP:		
Treating Practitioner's Tax Identification Number:		
Treating Practitioner's Phone Number:		-
Member's Name:	Member's DOB:	
Member's ID Number:		
Member/Guardian Signature:	Date:	

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Patient Summary Form PSF-750 (Rev. 7/1/2015)				Instructions Please complete thi All PSF submission	s form within the specified timeframe, s should be completed online at
Patient Information		nlo 🗆		www.myoptumhealt wise instructed.	hphysicalhealth.com unless other-
	○ Fema			Please review the F	lan Summary for more information.
Patient name Last First	MI Wildle	Patient dat	e of birth		
Patient address	City			State	Zip code
rauant acuress	- July			State	Zip code
Patient insurance ID#	Health plan		Group number		
					- 1124
Referring physician (if applicable)	Date referral issued (if applicable	9)	i Referral number (i	applicable)	
Provider Information				-	
Name of the bullet and facility		2 Fodovski tov ID	(Thi) of earth, in her	- #4	
i. Name of the billing provider or facility (as it will appear on the clair			(TIN) of entity in box		Jan Day
	1 MD/DO 2 DC 3 P	T 4 OT 5 Both PT ar	1d OT 6 Home C	are 7 ATC	8 MT 9 Other
s. Name and credentials of the individual performing the service	(e)			T	
	T NIBI of a selfer to				A. D.L.
4. Alternate name (if any) of entity in box #1	5. NPI of entity in	DOX #1		F	6. Phone number
					<u> </u>
7. Address of the billing provider or facility indicated in box #1	-	8. City		9. State	•
Provider Completes This Section:		Date of Su	rgery		agnosis (ICD codes) asse ensure all digits are
Date you want THIS submission to begin: Cause 6	of Current Episode	ا ا ا		40	entered accurately
(1) Traumat		Type of Surge	- :	1°	
(2) Unspeci	× 1	(1) ACL Reconstruc	tion	o.	1 1 1 1
Patient Type (3) Repetitiv	e (6) Motor vehicle	(2) Rotator Cuff/Lab	:	2°	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
New to your office	· ·	(3) Tendon Repair		3° 📑	
2 Est'd, new injury		Spinal Fusion	·	• <u> </u>	<u> </u>
3 Est'd, new episode		5 Joint Replaceme	ent	4° 📉	
Est'd, continuing care		6 Other			
Nature of Condition	DC ONLY			nctional Mea	eum Saam
(1) Initial onset (within last 3 months)	Anticipated CMT Level				sure Score
2 Recurrent (multiple episodes of < 3 months)	98940 () 98942	Neck Ind	lex	DASH	(other FOM)
(3) Chronic (continuous duration > 3 months)	98941 98943	Back Ind	lex	LEFS	(Guier i Om)
Patient Completes This Section: Sympto	oms began on:		Indicate wi	here you have	pain or other symptom
(Please fill in selections completely)			(r- -}	(<u>*</u>)
1. Briefly describe your symptoms:					
			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
2. How did your symptoms start?			<i>171</i>	44//	11/5:11
			1 Em	1	Zan () hus
3. Average pain intensity:	00000		h	IH/	1.11.1
Last 24 hours: no pain 0 1 2 3	456789	(10) worst pain		X)	(3/7)
Past week: no pain (0) (1) (2) (3)	456789	(10) worst pain	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	₩)
4. How often do you experience your symple (1) Constantly (76%-100% of the time) (2) Frequen		ocasionally (250) FOO	of the time\	752 1	
•	•			• •	0%-25% of the time)
5. How much have your symptoms interfe		`	g both work outside	the home and	housework)
0 0	erately (4) Quite a bit (,			
6. How is your condition changing, since	~ ~ ~	_	\wedge	^	^
(0) N/A — This is the initial visit (1) Much	worse (2) Worse (3) A little	worse (4) No chang	e (5) A little bet	ter (6) Bett	er (7) Much better
7. In general, would you say your overall	health right now is				
1 Excellent (2) Very good (3) Goo	-^ <i>/</i>) Poor			
Patient Signature: X	•	-	r	Date:	



ACN Group, Inc. Form NI-100

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Patient Name	Date
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This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ① I have no pain at the moment.
- The pain is very mild at the moment.
- The pain comes and goes and is moderate.
- 3 The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Sleeping

- I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- 3 My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- (5) My sleep is completely disturbed (5-7 hours sleepless).

Reading

- 1 can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- 3 I cannot read as much as I want because of moderate neck pain.
- 4 I can hardly read at all because of severe neck pain.
- (5) I cannot read at all because of neck pain.

Concentration

- I can concentrate fully when I want with no difficulty.
- 1 can concentrate fully when I want with slight difficulty.
- I have a fair degree of difficulty concentrating when I want.
- (3) I have a lot of difficulty concentrating when I want.
- A I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at ali.

Headaches

- 1 have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- 3 I have moderate headaches which come frequently.
- I have severe headaches which come frequently.

⑤ I have headaches almost all the time.

Personal Care

- I can look after myself normally without causing extra pain.
- 1 can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- 3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- 1 can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- 2 I can drive my car as long as I want with moderate neck pain.
- 3 I cannot drive my car as long as I want because of moderate neck pain.
- 4 I can hardly drive at all because of severe neck pain.
- (5) I cannot drive my car at all because of neck pain.

Recreation

- ① I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- 2 I am able to engage in most but not all my usual recreation activities because of neck pain.
- 3 I am only able to engage in a few of my usual recreation activities because of neck pain.
- I can hardly do any recreation activities because of neck pain.
- (5) I cannot do any recreation activities at all.

Work

- O I can do as much work as I want.
- 1 can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- 3 I cannot do my usual work.
- I can hardly do any work at all.
- (5) I cannot do any work at all.

Neck	
Index	
Score	

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100