Voluntary Prior Approval Process

1. 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 Patient Summary Form along with this signed Voluntary Prior Approval Agreement Form 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.*

3. 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: _____

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

Patient name: Last | First | MI — ○ Female ○ 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) — 1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 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:

Cause of Current Episode
1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery
1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other _____

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1° 2° 3° 4°

Patient Type
1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Nature of Condition
1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level
○ 98940 ○ 98942 ○ 98941 ○ 98943

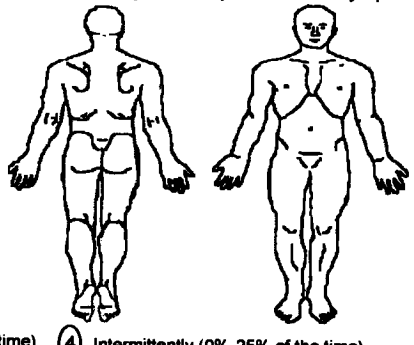
Current Functional Measure Score
Neck Index | DASH | (other FOM)
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



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

Patient Signature: X _____ **Date:** _____

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____/ 80

Please submit the sum of responses.

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