

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

Provider Information

<input type="text"/>		<input type="text"/>																				
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																				
<input type="text"/>		<input type="text"/>																				
<table style="width:100%; border:none;"> <tr> <td style="border:1px solid black; padding:2px;">1</td> <td style="border:1px solid black; padding:2px;">MD/DO</td> <td style="border:1px solid black; padding:2px;">2</td> <td style="border:1px solid black; padding:2px;">DC</td> <td style="border:1px solid black; padding:2px;">3</td> <td style="border:1px solid black; padding:2px;">PT</td> <td style="border:1px solid black; padding:2px;">4</td> <td style="border:1px solid black; padding:2px;">OT</td> <td style="border:1px solid black; padding:2px;">5</td> <td style="border:1px solid black; padding:2px;">Both PT and OT</td> <td style="border:1px solid black; padding:2px;">6</td> <td style="border:1px solid black; padding:2px;">Home Care</td> <td style="border:1px solid black; padding:2px;">7</td> <td style="border:1px solid black; padding:2px;">ATC</td> <td style="border:1px solid black; padding:2px;">8</td> <td style="border:1px solid black; padding:2px;">MT</td> <td style="border:1px solid black; padding:2px;">9</td> <td style="border:1px solid black; padding:2px;">Other</td> <td style="border:1px solid black; padding:2px;">_____</td> </tr> </table>				1	MD/DO	2	DC	3	PT	4	OT	5	Both PT and OT	6	Home Care	7	ATC	8	MT	9	Other	_____
1	MD/DO	2	DC	3	PT	4	OT	5	Both PT and OT	6	Home Care	7	ATC	8	MT	9	Other	_____				
3. Name and credentials of the individual performing the service(s)																						
<input type="text"/>																						
4. Alternate name (if any) of entity in box #1		5. NPI of entity in box #1																				
<input type="text"/>		<input type="text"/>																				
6. Phone number		7. Address of the billing provider or facility indicated in box #1																				
<input type="text"/>		<input type="text"/>																				
8. City		9. State																				
<input type="text"/>		<input type="text"/>																				
10. Zip code		<input type="text"/>																				

Provider Completes This Section:

<p>Date you want THIS submission to begin:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"><input type="text"/></td> <td style="width:25%;"><input type="text"/></td> <td style="width:25%;"><input type="text"/></td> <td style="width:25%;"><input type="text"/></td> </tr> </table> <p>Patient Type</p> <p><input type="radio"/> (1) New to your office</p> <p><input type="radio"/> (2) Est'd, new injury</p> <p><input type="radio"/> (3) Est'd, new episode</p> <p><input type="radio"/> (4) Est'd, continuing care</p>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<p>Cause of Current Episode</p> <p><input type="radio"/> (1) Traumatic <input type="radio"/> (4) Post-surgical</p> <p><input type="radio"/> (2) Unspecified <input type="radio"/> (5) Work related</p> <p><input type="radio"/> (3) Repetitive <input type="radio"/> (6) Motor vehicle</p>	<p>Date of Surgery</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"><input type="text"/></td> <td style="width:25%;"><input type="text"/></td> <td style="width:25%;"><input type="text"/></td> <td style="width:25%;"><input type="text"/></td> </tr> </table> <p>Type of Surgery</p> <p><input type="radio"/> (1) ACL Reconstruction</p> <p><input type="radio"/> (2) Rotator Cuff/Labral Repair</p> <p><input type="radio"/> (3) Tendon Repair</p> <p><input type="radio"/> (4) Spinal Fusion</p> <p><input type="radio"/> (5) Joint Replacement</p> <p><input type="radio"/> (6) Other _____</p>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<p>Diagnosis (ICD code)</p> <p><i>Please ensure all digits are entered accurately</i></p> <p>1° <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>2° <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>3° <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>4° <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<p>Nature of Condition</p> <p><input type="radio"/> (1) Initial onset (within last 3 months)</p> <p><input type="radio"/> (2) Recurrent (multiple episodes of < 3 months)</p> <p><input type="radio"/> (3) Chronic (continuous duration > 3 months)</p>	<p style="text-align:center;">DC ONLY</p> <p style="text-align:center;">Anticipated CMT Level</p> <p><input type="radio"/> 98940 <input type="radio"/> 98942</p> <p><input type="radio"/> 98941 <input type="radio"/> 98943</p>	<p>Current Functional Measure Score</p> <p>Neck Index <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>Back Index <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>DASH <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>LEFS <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p style="text-align:right;">(other) <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>												
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Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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

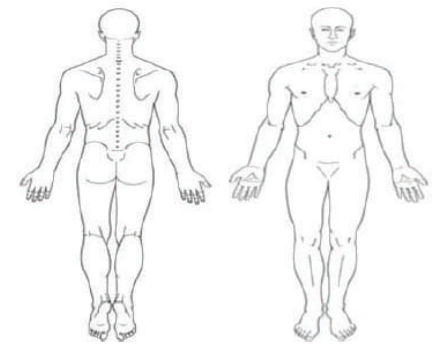
6. How is your condition changing, since care began at this facility?

(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

Indicate where you have pain or other symptoms:



Patient Signature: X **Date:** _____