

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

Female
 Male

Patient name: Last [] First [] MI [] 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) []

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:

[] [] []

Patient Type

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

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° [] [] [] [] [] []

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 [] [] []

Back Index [] LEFS [] (other FOM)

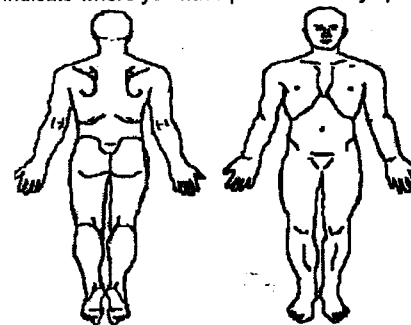
Patient Completes This Section:

(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: [] [] []