

# Fax Cover Sheet

OptumHealth Care Solutions, LLC rev 01/03/2013

Provider State: \_\_\_\_\_

Date: \_\_\_\_\_

# of Pages: \_\_\_\_\_  
(Including cover)

To: OptumHealth Care Solutions

From: Provider's Name: \_\_\_\_\_

Contacts' Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

## Instructions for Use

1. To insure the most rapid delivery to the intended recipient, please direct this fax to a specific person.
2. When sending information to the Clinical Support Department, please indicate the provider state, patient name, health plan, the number of pages being submitted for the patient, and select the type of documentation included.

## Clinical Support Department

Attention: \_\_\_\_\_ (Support Clinician or Dept. name here.)

Health Plan: \_\_\_\_\_

Submission #: \_\_\_\_\_

**Patient Name****# of Pages**

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

- ☐ Pediatric Documentation Included
- ☐ Neurologic Documentation Included
- ☐ Auto Liability Documentation Included
- ☐ Worker's Compensation Documentation Included
- ☐ Support Clinician Requested Documentation Included

Memo:

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# 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](http://www.myoptumhealthphysicalhealth.com) unless otherwise instructed.

Please review the Plan Summary for more information.

### Patient Information

|                                     |             |                                      |              |                                 |                       |  |
|-------------------------------------|-------------|--------------------------------------|--------------|---------------------------------|-----------------------|--|
| Patient name Last                   |             | First                                | M            | <input type="radio"/> Female    | 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:

Symptoms began on:

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

(Please fill in selections completely)

1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

|                |         |                         |                         |                         |                         |                         |                         |                         |                         |                         |                         |                          |            |
|----------------|---------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|--------------------------|------------|
| 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 |
| 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 |

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: \_\_\_\_\_

Indicate where you have pain or other symptoms:

