

# 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)

**Patient Information**

			<input type="radio"/> Female		
			<input type="radio"/> 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	
<input type="checkbox"/> MD/DO <input type="checkbox"/> DC <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Both PT and OT <input type="checkbox"/> Home Care <input type="checkbox"/> ATC <input type="checkbox"/> MT <input type="checkbox"/> Other _____			
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		B. City	9. State 10. Zip code

**Provider Completes This Section:**

Date you want **THIS**  
submission to begin:

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

Date of Surgery			Diagnosis (ICD codes) Please ensure all digits are entered accurately		
<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"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Patient Type**

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

DC ONLY	
Anticipated CMT Level	
<input type="radio"/> 98940	<input type="radio"/> 98942
<input type="radio"/> 98941	<input type="radio"/> 98943

**Current Functional Measure Score**

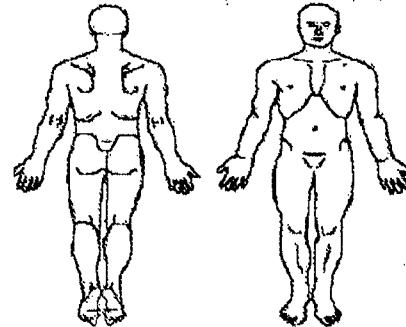
Neck Index	<input type="text"/>	DASH	<input type="text"/>	(other FOM)
Back Index	<input type="text"/>	LEFS	<input type="text"/>	

**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  1  2  3  4  5  6  7  8  9  10 worst pain  
 Past week:  no pain  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: \_\_\_\_\_