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Outpatient Therapy Progress Report

This form should be filled out and submitted by the physical therapist when it is determined that the member will require additional visits to meet his/her goals. Please submit this form along with a copy of the referring physician's prescription for therapy. All forms can be submitted via fax to 1-855-231-8664.

Member information		
Last name:	First name:	
Member ID:	DOB:	Sex:

Provider information	
Provider name:	Provider NPI:
Phone:	Fax:
Contact name:	Extension:

Primary diagnosis and current pain rating	
Diagnosis (ICD-9) code:	
Description:	
Current pain rating: _____/10	Changes in symptoms: ☐ Improved ☐ Worsened ☐ Unchanged
New symptoms reported:	

Functional assessment and progression to date	
Tests/measures:	
Functional limitations: ☐ Improved ☐ Worsened ☐ Unchanged	
Describe if improved or worsened:	
Short-term goals: ☐ Completely met ☐ Partially met ☐ Not met	
Therapy attendance: ☐ Consistent ☐ Inconsistent	HEP compliance: ☐ Consistent ☐ Inconsistent
Previous authorization was for _____ visits.	Member has completed _____ of those visits.
Date of last visit:	

Updated prognosis and plan of care	
Prognosis (Potential to reach maximum functional level): ☐ Excellent ☐ Good ☐ Fair ☐ Poor	
Continue physical therapy _____ times per week for _____ (number of weeks)	
Continue occupational therapy _____ times per week for _____ (number of weeks)	
Long-term goals (expected number of visits to achieve):	
Increase ROM by _____ degrees	Increase strength by _____ grade(s)
Decrease pain to _____/10 independent HEP	Restore 100% of prior level of function _____

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

Therapy request
Based upon my updated assessment performed, I am requesting authorization for _____ visits over _____ days.

Therapist's signature: _____ Date: _____