SOUND HEALTH & WELLNESS TRUST
PHYSICAL THERAPY PRE-AUTHORIZATION REQUEST FORM

TO: SOUND HEALTH & WELLNESS TRUST PRE-AUTHORIZATIONS FAX # 206-285-4437
CLINIC / PROVIDER NAME:_____ PH#: _____
FAX#: _____ ADDRESS: _____

Please type or print legibly

Date _____

Ordering Physician: _____ Physician Phone: _____

Member Name: _____ Member SS/ID #: _____

Patient Name: _____ Patient Date of Birth: _____

☐ Initial Request **OR** ☐ Continued Therapy Request **Begin date for this request: _____**

Information required to consider Pre-Authorization Request

☐ Physician Referral and related treatment/office clinic notes

☐ History and Physical from referring physician

☐ Progress notes and daily notes from Physical Therapist

☐ The most current Physical Therapy Treatment Plan signed by Physician (see below)***,** or attach MD order

Diagnosis/ICD-9 Code: _____

Date of Initial Evaluation: _____

Frequency of Visits: _____ Duration of Treatment: _____

Treatment Plan with goals: _____

_____

_____

_____

Prognosis: _____

Estimated Date of Discharge: _____

PRESCRIBING PHYSICIAN: *

☐ Continue RX (as above) ☐ Change RX _____

☐ Discontinue RX ☐ RX Frequency_____/week for _____ weeks ☐ PRN

Comments: _____

_____

Physicians Signature: _____ Date: _____