PSF-750 Quick Reference Guide

Have your **patient** complete:

- **Patient section** and
- **Functional outcome measure** (recommended, but not required)

The provider billing for services should complete the remainder of the document.

The Patient Summary Form must be received by OptumHealth **no later than ten (10) days** from the submission start date. The Patient Summary Form can also be submitted online at http://www.myoptumhealthphysicalhealth.com/
For further process details, please view the tutorial at http://www.myoptumhealthphysicalhealth.com/

Complete patient demographic information

Name and credentials of the practitioner who is rendering or providing the service

*State date for THIS Submission

Indicate the patient type for THIS submission

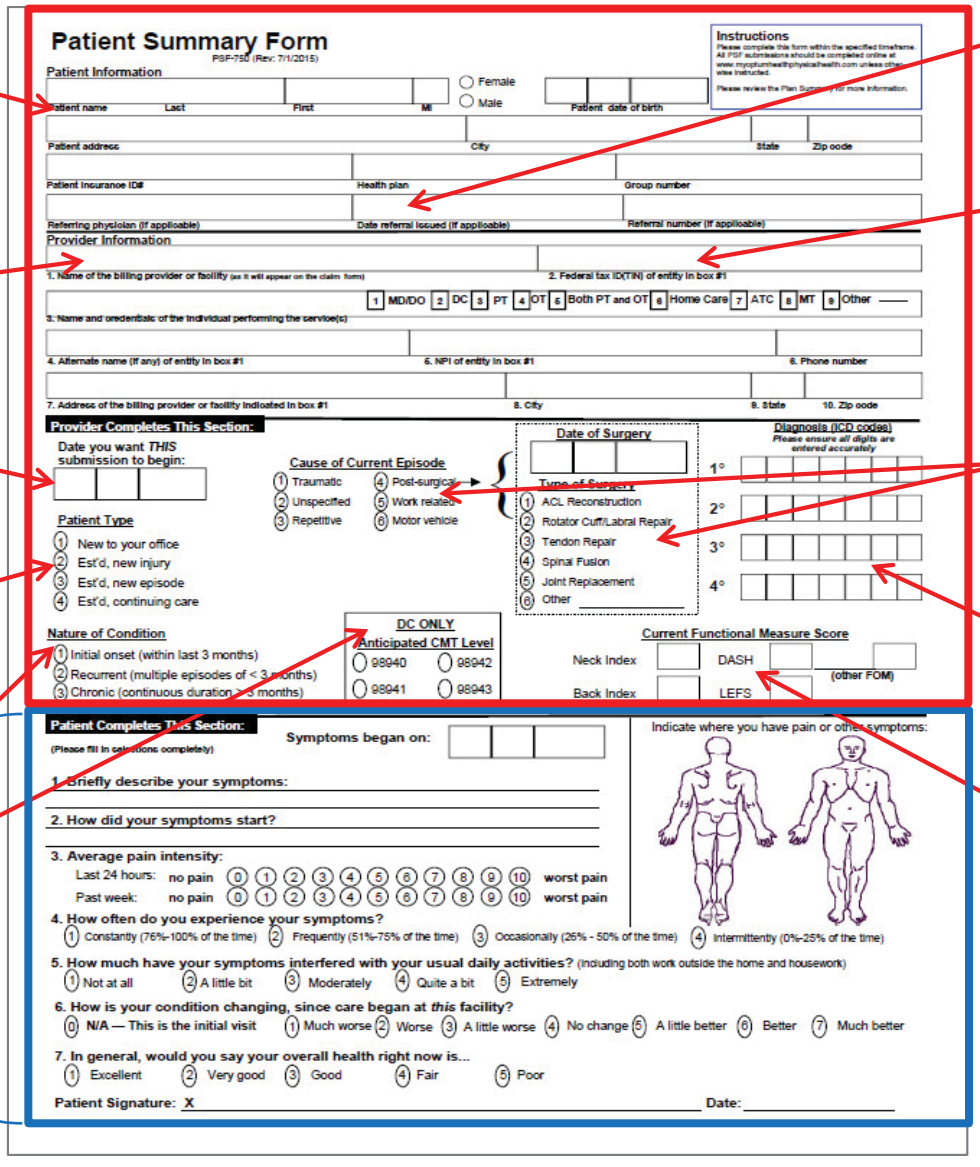
Nature of patient's condition for THIS episode

(Chiropractic use only)

Indicate anticipated CMT level

Patient completes this section.

Please encourage patients to complete as accurately as possible, based on current status



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

Patient name: Last, First, MI | Female / Male | 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

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1 | 6. 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:

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°

Patient Type

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

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: _____

Enter referral information (If applicable)

Please ensure that the TIN used is the SAME TIN entered on the claim, which should correlate to the name of the business entity, facility and/or billing provider

Enter the cause of the current episode of care and/or surgical date and type being addressed during THIS episode of care

Enter the ICD diagnosis code(s)* that represent the condition(s) that are being addressed during THIS episode of care

Please complete a Functional Outcome Measure and document the score in this section

*For Clinical Submissions with start date before 10/1/2015 please use ICD-9 codes.
For Clinical Submissions with start date on/after 10/1/2015 only ICD-10 codes will be accepted.