



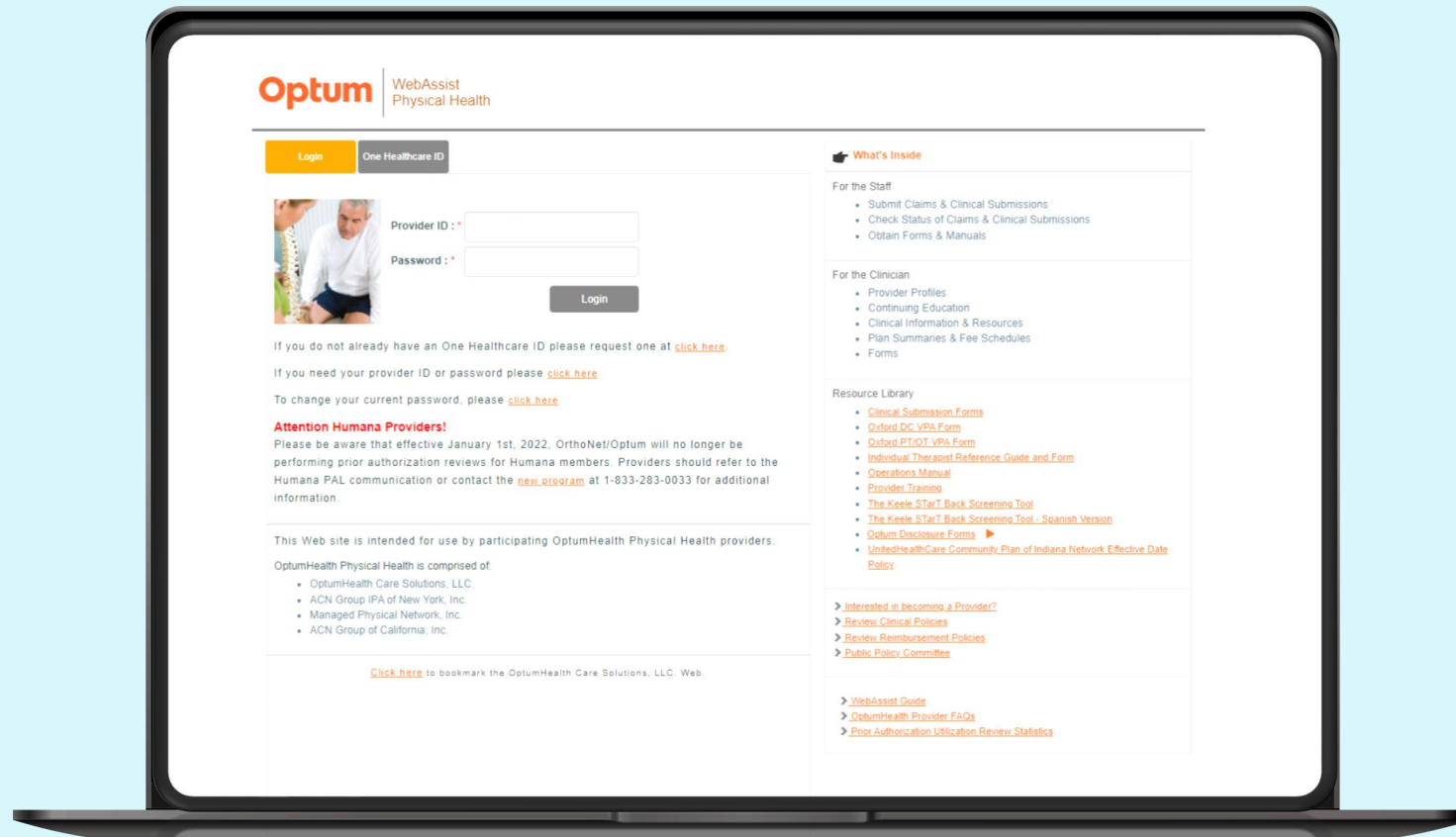
Welcome to WebAssist Optum Provider Portal

Discover How to Submit a PSF-750 Online

Published June 2024

Online Submission of the Patient Summary Form (PSF-750) is Required

You must submit forms within 3 days but no later than 10 days.



The following directions will assist in making the online submission process easy and convenient for you and your staff.



Index

- 4-5** Obtain ID and Password
- 6-7** Determine if Clinical Submission is Required – UHC Medicare Members
- 8** Member Eligibility and Benefits
- 9-13** Enter a PSF-750 Electronically
- 15-16** Enter a PSF-750 Electronically – Medicare Addendum
- 17-18** Administrative Corrections
- 19** Current Functional Measure Score
- 20** Submit
- 21** Confirmation Page
- 22-25** Authorization Status Check
- 26** Technical Assistance

Obtain Your Optum User ID and Password

When logging into the portal for the first time, you must have a six-digit Optum provider ID and password.

To request this information, click the link directly below the 'Login' button.

If Optum has your current office email on file, the ID and password will be emailed to you directly. If Optum does not have the current email on file, then your request will be mailed to your office.

Once you login using this information, you will be redirected to the One Healthcare ID portal to set up your One Healthcare ID and password.

The image displays two overlapping screenshots of web portals. The background screenshot is the Optum WebAssist Physical Health login page. It features the Optum logo and 'WebAssist Physical Health' text. A red box highlights the 'Login' button. Below it, there are input fields for 'Provider ID' and 'Password', followed by another 'Login' button. A red box highlights a link that reads 'If you need your provider ID or password please click here'. The foreground screenshot is the One Healthcare ID portal. It shows a 'Sign In' section with a text input for 'One Healthcare ID or Email Address' and a 'Continue' button. Below this is a 'Create One Healthcare ID' button. There is also a 'Manage My One Healthcare ID' button. A sidebar on the left of the foreground screenshot contains a 'Secure your account by moving away from Passwords' section with a 'Get Started' button. At the bottom of the foreground screenshot, there are links for 'Chat with support' and 'Help Center'.

Obtain Your One Healthcare ID and Password

Once you've logged in and created a One Healthcare ID and password, you will click on the One Healthcare ID login tab, use this ID and password to log into WebAssist in the future.

If you have any difficulty, you can also call our customer service center and they can assist you. Call: 800-873-4575 or 888-676-7768

The image shows two overlapping screenshots of the Optum WebAssist Physical Health website. The top screenshot is the main login page, featuring the Optum logo and 'WebAssist Physical Health' text. It has two tabs: 'Login' and 'One Healthcare ID', with the latter highlighted by a red box. Below the tabs, there's a section titled 'One Healthcare ID empowers the user to...' with a 'Login' button. At the bottom, it says 'If you do not already have an One Healthcare ID please request one' and 'If you need your provider ID or password please [click here](#)'. The bottom screenshot is the 'One Healthcare ID' sign-in page, showing a 'Sign In' section with a text input for 'One Healthcare ID or Email Address', a 'Continue' button, and links for 'Forgot One Healthcare ID?', 'Create One Healthcare ID', and 'Manage My One Healthcare ID'. There's also a 'Secure your account by moving away from Passwords' section with a 'Get Started' button and a 'Chat with support' / 'Help Center' footer.

Determine if Clinical Submission is Required

To determine if your UnitedHealthcare Medicare Advantage member* requires clinical submission, click on the Tools & Resources menu, then click 'M&R Quick Group Check.'

*Excludes UnitedHealthcare Medicare Solutions West

Optum WebAssist Physical Health

Welcome, Links Help Sign Out

Physical Health Locations

Clinical Subs & Claims Tools & Resources Clinical Resources Home

Member Eligibility Submit a Clinical Sub Clinical

Patients

Begin by entering the patients information or select an existing patient from the Patients list.

SUBMIT A PATIENT SUMMARY FORM

Providers may request a visit on an urgent basis if the Department of Labor urgent care application of the time period for making a non-urgent care determination could seriously affect the ability of the patient to regain maximum function. A determination for urgent care will require the following information.

During Optum business hours providers may reference the phone number in the application for urgent care. 6809 during non-Optum business hours to initiate a request for urgent care.

Physical Health Provider Support Click here for live chat

Patient's Demographic Section

Last Name First Name MI Gender DOB (mm/dd/yyyy)

Tools & Resources dropdown menu:

- Network News
- Operations Manuals
- Plan Summaries
- Fee Schedules
- State Regulatory Addendums
- Patient Satisfaction Result
- Patient Satisfaction CAHPS
- Tutorial
- CAHPS Survey Methodology
- Forms
- Patient Status Report Reference Guide
- Electronic Claims
- UHC Quick Group Check
- M&R Quick Group Check**
- Reimbursement Policies
- California Language Assistance
- Information
- CMS Fraud, Waste & Abuse
- Provider Training

Determine if Clinical Submission is Required

The M&R Quick Group Check requires entering individual member's group number. Once you enter, click 'Submit.'

Welcome,

Links ▾ ? Help Sign Out

Optum

WebAssist
Physical Health

Physical Health Locations

Clinical Subs & Claims ▾

Tools & Resources ▾

Clinical Resources ▾

Home

Network News ▶

Operations Manuals

Plan Summaries

Fee Schedules

State Regulatory Addendums

Patient Satisfaction Result

Patient Satisfaction CAHPS Tutorial

CAHPS Survey Methodology

Forms ▶

Patient Status Report Reference Guide

Electronic Claims

UHC Quick Group Check

M&R Quick Group Check

Clinical submission requirements differ by member groups. Quick Group Check allows you to check submission requirements for commercial plans (not Medicare or Medicaid/Community/State plans). Quick Group Check only works for UnitedHealthcare groups with a 5-character Group Number, with either all numeric characters (example: 70168) or numeric with the second character a letter (example: 3U585). For other Groups, please see the Plan Summary for submission requirements. Enter the 5-character UnitedHealthcare Group Number below as it appears on the member's ID card to determine if a submission is required.

Member's Group Number:

Submit

Reset

Member Eligibility and Benefits

Providers are required to verify member eligibility and benefits online.

Under Clinical Subs & Claims menu, click 'Member Eligibility'.

Enter the member's name, ID and date of birth, then click 'Find Member.'

Welcome, John Chiropractor, DC,MT,LAC, Tier 2

Links Help Sign Out

OptumWebAssist
Physical Health

Physical Health Locations

Activity Center

Clinical Submissions and Claims

Clinical Submissions

Submit

Check Status

Claims

Submit

Check Status

Clinical Subs & Claims

Member Eligibility

Submit a Clinical Sub

Clinical Sub Status

Submit a Claim

Claim Status

Tools & Resources

Clinical Resources

Home

Pediatric therapies (OT)

ing Process - UHC Commercial plan only

Reminder Notification: Provider Tier Letters Now Online!

Effective January 1, 2022, all Providers need to update their CAQH Profile on a regular basis

Welcome, John Chiropractor, DC,MT,LAC, Tier 2

Links Help Sign Out

OptumWebAssist
Physical Health

Physical Health Locations

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Home

Member Eligibility

Submit a Clinical Sub

Clinical Sub Status

Submit a Claim

Claim Status

Patients

A B C D E F

G H I J K L

M N O P Q R

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Member Search

Health Plan*

Please Select

(If you do not see the Health Plan listed, please check your Plan Summary for Eligibility Verification)

Last Name*

First Name*

ID*

DOB*

mm/dd/yyyy

Group Number

Find Member

Clear

PSF-750 Form

Many offices print a hard copy of the PSF-750 first, have the provider and the patients fill out their sections, and then enter the information electronically on the Optum portal.

You can find the PSF-750 hard copy under the “Tools & Resources” menu click on Clinical Forms.

You will be presented with clinical forms. Click Patient Summary Form PSF-750.

Medicare requires some additional questions be answered that are not included in the paper PSF-750. See pages 15-16 for additional information.

The screenshot displays the Optum WebAssist Physical Health portal interface. At the top, a navigation bar includes the user's name 'Welcome, John Chiropractor, DC, MT, LAC, Tier 2' and links for 'Links', 'Help', and 'Sign Out'. The main header features the Optum logo and 'WebAssist Physical Health'. Below this, a secondary navigation bar contains 'Physical Health Locations', 'Clinical Subs & Claims', 'Tools & Resources', 'Clinical Resources' (highlighted with a red box and a red circle with the number 1), and 'Home'. A left sidebar menu includes 'Activity Center', 'Clinical Submissions and Claims', 'Clinical Submissions' (with 'Submit' and 'Check Status' links), and 'Recent Clinical Submissions' (with a message about no recent submissions and a 'See Recent Clinical Submissions' link). The main content area is titled 'Informational Center' and contains a link to 'Pediatric therapies (OT/PT) Clinical Review Faxing Process - UHC Community'. Below this, a 'Clinical Forms' section is highlighted with a red box and a red circle with the number 2. It contains a list of forms, with 'Patient Summary Form PSF-750' highlighted by a red box and a red circle with the number 3. Other forms listed include 'Fax Cover Sheet', 'Patient Summary Form Quick Reference Guide', 'Patient Summary Form PSF-750 - Chinese Version', 'Patient Summary Form PSF-750 - Spanish Version', 'Disabilities of the Arm, Shoulder and Hand (DASH)', 'Lower Extremity Functional Scale (LEFS)', 'Back Index', 'Neck Index', and 'The Keele STarT Back Screening Tool'.

Submit a PSF Electronically

To submit the PSF-750 electronically, in the Activity Center, click 'Submit' under Clinical Submissions.

Welcome, John Chiropractor, DC,MT,LAC, Tier 2

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Physical Health

Physical Health Locations

Clinical Subs & Claims Tools & Resources

Activity Center

Clinical Submissions and Claims

Clinical Submissions	Claims
Submit	Submit
Check Status	Check Status

Recent Clinical Submissions

Informational Center

Pediatric therapies (OT/PT) Clinical Review Faxing Process - UHC Comme

Reminder Notification: Provider Tier Letters Now Online! ▶

Effective January 1, 2022, all Providers need to update their CAQH Profil

Effective July 1 all clinical sub status must be tracked online ▶

Submit a PSF Electronically – Patient Information

For established patients, pick their name off the patient list, which is in alphabetical order by last name. Their demographics will then populate in the form on the right.

For a new patient fill out the patient demographics section in the blank form.

If you have an established patient who has changed their name, address, or health insurance plan, complete a **new submission**, and include the new information as you would for a any other new patient.

Once the PSF is processed the patient’s name with the new information will display on your patient list.

Optum

WebAssist
Physical Health

Physical Health Locations

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Home

Member Eligibility

Submit a Clinical Sub

Clinical Sub Status

Submit a Claim

Claim Status

Patients

A

B

C

D

E

F

G

H

I

J

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test, Patient

Physical Health Provider Support

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Begin by entering the patients information or select an existing patient from the Patients list.

Currently Selected Patient:

None

Clear Patient

SUBMIT A PATIENT SUMMARY FORM

Providers may request a visit on an urgent basis if the Department of Labor urgent care definition is met. Care may qualify as urgent if the application of the time period for making a non-urgent care determination could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function. A determination for urgent care will be issued within 24 hours of Optum receiving all required information.

During Optum business hours providers may reference the phone number in the applicable Plan Summary. Providers may call 877-271-6809 during non-Optum business hours to initiate a request for urgent care.

Patient's Demographic Section

Last Name

First Name

MI

Gender

DOB (mm/dd/yyyy)

ID#

mm/dd/yyyy

Male

Female

Address

City

State

Zip

Plan:

Group Number

Optum

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11

Submit a PSF Electronically – Patient Information – Plan Name

In the ‘Plan’ section, make sure to select the appropriate Plan name, corresponding to the member’s card, from the dropdown.

For Example: For UnitedHealthcare Medicare Advantage plans¹, select UnitedHealthcare Medicare, For UnitedHealthcare Medicare Solutions West² Select “United Healthcare Medicare Solutions West”.

Begin by entering Patients list.

1

2

UnitedHealthcare UCard

MEMBER A SAMPLE

Member ID 123456789-00
AARP Medicare Advantage Patriot No Rx NJ-MA01 (HMO-POS)
With Dental

RxBIN RxCN RxGRP
610494 9999 COS

Group Number: 40551 H0755-037-000
PCP: PROVIDER
PCP: 555-555-5555
PCP \$0 Spec \$40

Printed: 09-28-2023 Rewards

Card #: 12345 6789 0123 4567
Security Code: 1234
For Members: myAARPmedicare.com
1-866-314-8188, TTY 711

Providers: UHCprovider.com 1-877-842-3210
Payer ID: 87726
Dental Providers: uhcdental.com 1-877-816-3596
Med Claims: P.O. Box 31362, Salt Lake City, UT 84131-0362
Part B Rx Claim: OptumRx P.O. Box 650287, Dallas, TX 75265-0287
For Pharmacists: 1-877-889-6510
中文: 1-800-303-6719 한국어: 1-888-201-4746

Printed: 09-28-2023 Rewards

Card #: 12345 6789 0123 4567
Security Code: 1234
For Members: myAARPmedicare.com
1-844-808-4553, TTY 711

Providers: UHCprovider.com 1-888-866-8297
Payer ID: 87726 WEST
Dental Providers: uhcdental.com 1-877-816-3596
Med Claims: P.O. Box 30968, Salt Lake City, UT 84130-0968
Rx Claims: OptumRx P.O. Box 650287, Dallas, TX 75265-0287
For Pharmacists: 1-877-889-6510

Plan: Please select

Group Number

Please select your Clinic Address

Submit a PSF Electronically – Provider Office Information

After selecting an existing patient, or entering your new patient information, you must select the office location where the patient is being treated.

Once you select the location, the remainder of the electronic PSF-750 will display.

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Physical Health Locations

Clinical Subs & Claims

Member Eligibility

Submit a Clinical Sub

Patients

A B C D E F
G H I J K L
M N O P Q R
S T U V W X
Y Z

Test, Test

01/01/1962

Physical Health Provider Support

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Verify the patient's information is correct, and then select your Office Location to begin completing the clinical submission form.

SUBMIT A PATIENT SUMMARY FORM

Patient's Demographic Section

Last Name

First Name

MI

Gender

DOB (mm/dd/yyyy)

ID#

Plan:

UnitedHealthcare Medicare

Clinical Information

Office Location with TIN number

Please select your Clinic Address

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Physical Health Locations

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Home

Member Eligibility

Submit a Clinical Sub

Clinical Sub Status

Submit a Claim

Claim Status

Patients

A B C D E F
G H I J K L
M N O P Q R
S T U V W X
Y Z

Test, Test

01/01/1962

Physical Health Provider Support

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Patient Summary Form

Patient Information

Last Name

First Name

MI

Gender

DOB

Address

City

State

Zip

ID#

Health Plan

Group Number

Referral Information

Physician

Date Issued

mm/dd/yyyy

Referral Number

Provider Information

John Chiropractor, DC, MT, LAC

Office Location

Credentials

Setting

Would you like to attach additional documents to this Clinical Submission?

Upload/View Documents

Upload Instructions

Is this an Administrative Correction to a Previous Submission?

Provider Completes This Section

Date you want THIS submission to begin

Number of visit(s) within past 90 days

Requested duration in weeks

Requested number of visits

Patient Type

Nature of Condition

Cause of Current Episode

Anticipated CMT Level

Diagnosis (ICD code)

Nature of Treatment

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13

Submit a PSF Electronically – Clinical Information




Enter all required the clinical information within the electronic form.

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[Physical Health Locations](#) [Clinical Subs & Claims](#) [Tools & Resources](#) [Clinical Resources](#) [Home](#)

[Member Eligibility](#) [Submit a Clinical Sub](#) [Clinical Sub Status](#) [Submit a Claim](#) [Claim Status](#)

Patients



Test, Test 01/01/1962

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Patient Summary Form

Patient Information

Last Name: First Name: MI: Gender: DOB:

Address: City: State: Zip:

ID# Health Plan: Group Number:

Referral Information

Physician: (if applicable) Date Issued: (if applicable) mm/dd/yyyy Referral Number: (if applicable)

Provider Information

John Chiropractor, DC, MT, LAC Office Location:

*Credentials: ☐ MD/DO ☐ DC ☐ OT ☐ PT ☐ ATC ☐ MT ☐ ST ☐ Other

*Setting: Is this Home Care Setting? ☐ Yes ☐ No

Would you like to attach additional documents to this Clinical Submission? [Upload/View Documents](#) [Upload Instructions](#)

Is this an Administrative Correction to a Previous Submission? ☐

Provider Completes This Section

*Date you want THIS submission to begin: mm/dd/yyyy *Number of visit(s) within past 90 days:

*Requested duration in weeks: *Requested number of visits:

*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)

*Cause of Current Episode:

☐ Traumatic ☐ Unspecified ☐ Repetitive ☐ Post-surgical ☐ Work related ☐ Motor vehicle

*Anticipated CMT Level:

Submit a PSF Electronically – Medicare Plans Only



When submitting a PSF for a UHC Medicare Advantage Plan or UHC Medicare Solutions (WEST) members, you will be presented with some additional questions, which will not be present for other plans.

The requested duration in weeks should be the **total number of weeks** of this requested treatment plan.

The requested number of visits should be the total number of visits, not the frequency of visits requested per week. *(i.e. 2 times per week for 8 weeks, equals 16 visits.)*

Provider Information

PT Healthcare, OT,PT,HC Office Location: 1234 Test Avenue, Miami, FL - *****9999

*Auth Type Submitting for/Credentials: ☐ MD/DO ☐ DC ☐ OT ☐ PT ☐ ATC ☐ MT ☐ ST ☐ Other

*Place of Service

☐ 11=Office - Outpatient ☐ 12=Homecare ☐ 19=Off-Campus Outpatient Hospital ☐ 22=Hospital - Outpatient ☐ 24=Outpatient Facility ☐ Other

Provider Completes This Section

*Date you want THIS submission to begin: mm/dd/yyyy *Number of visit(s) within past 90 days:

*Requested duration in weeks:

*Requested number of visits:

*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)

*Cause of Current Episode:
☐ Traumatic ☐ Unspecified ☐ Repetitive ☐ Post-surgical ☐ Work related ☐ Motor vehicle

*Diagnosis (ICD code):
Dx1 Dx2 Dx3 Dx4 *Nature of Treatment:

(Other)

*Objective measurements identify impairments when they are compared to normal values, the uninvolved contralateral extremity, and prior level of function.
☐ Yes ☐ No

*Objective assessment of functional ability. ☐ Choose One
☐ No functional limitations ☐ Minimal functional limitations ☐ Moderate functional limitations ☐ Severe functional limitations

*Documented plan of care (POC) requiring skilled intervention. ☐ Choose All That Apply
☐ Measurable short and long-term/discharge treatment goals related to physical and functional deficits.
☐ Frequency of treatment visits and treatment activities to address deficit areas.
☐ Patient agrees to program participation including home program.

Submit a PSF Electronically – Medicare Plans Only



Medicare requires some additional questions be answered that are not included in the paper PSF-750.

(Other)

*Objective measurements identify impairments when they are compared to normal values, the uninvolved contralateral extremity, and prior level of function.

☐ Yes ☐ No

*Objective assessment of functional ability. Choose One

☐ No functional limitations ☐ Minimal functional limitations ☐ Moderate functional limitations ☐ Severe functional limitations

*Documented plan of care (POC) requiring skilled intervention. Choose All That Apply

☐ Measurable short and long-term/discharge treatment goals related to physical and functional deficits.

☐ Frequency of treatment visits and treatment activities to address deficit areas.

☐ Patient agrees to program participation including home program.

Provider Information

PT Healthcare: OT, PT, HC Office Location: 1234 Test Avenue, Miami, FL - *****9999

*Auth Type Submitting for/Credentials: ☐ MD/DO ☐ PC ☐ OT ☐ PT ☐ ATC ☐ MT ☐ ST ☐ Other

*Place of Service

☐ 11-Office - Outpatient ☐ 12-Homecare ☐ 19-Off-Campus Outpatient Hospital ☐ 22-Hospital - Outpatient ☐ 24-Outpatient Facility ☐ Other

Provider Completes This Section

*Date you want THIS submission to begin: mm/dd/yyyy *Number of visit(s) within past 90 days:

*Requested duration in weeks: *Requested number of visits:

*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)

*Cause of Current Episode:

☐ Traumatic ☐ Unspecified ☐ Repetitive ☐ Post-surgical ☐ Work related ☐ Motor vehicle

*Diagnosis (ICD code):

Dx1: Dx2: Dx3: Dx4: *Nature of Treatment:

(Other)

*Objective measurements identify impairments when they are compared to normal values, the uninvolved contralateral extremity, and prior level of function.

☐ Yes ☐ No

*Objective assessment of functional ability. Choose One

☐ No functional limitations ☐ Minimal functional limitations ☐ Moderate functional limitations ☐ Severe functional limitations

*Documented plan of care (POC) requiring skilled intervention. Choose All That Apply

☐ Measurable short and long-term/discharge treatment goals related to physical and functional deficits.

☐ Frequency of treatment visits and treatment activities to address deficit areas.

☐ Patient agrees to program participation including home program.

Submit a PSF Electronically – Administrative Corrections

If you need to make a change to a previously submitted PSF, either before or after you receive a determination letter, you can do so directly on the site.

Simply pull up a new PSF-750 form, pick your patient or type in the patient's demographics and then click check box for 'Is this an Administrative Correction to a Previous Submission?'

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Physical Health

[Physical Health Locations](#)

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Home

Member Eligibility

Submit a Clinical Sub

Clinical Sub Status

Submit a Claim

Claim Status

Patients

A B C D E F

G H I J K L

M N O P Q R

S **T** U V W X

Y Z

Test, Test

01/01/1962

Physical Health Provider Support

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Patient Summary Form

Patient Information

Last Name: Test

First Name: Test

MI:

Gender: M

DOB: 01/01/1962

Address: 123 Test

City: Test

State: OR

Zip: 97814

ID#: 1111111111

Health Plan: UnitedHealthcare Medicare

Group Number:

Referral Information

Physician:

Date Issued:

mm/dd/yyyy

Referral Number:

(if applicable)

(if applicable)

(if applicable)

Provider Information

John Chiropractor, DC, MT, LAC

Office Location: 999999 Test, Denver, CO - *****8984

*Credentials: ☐ MD/DO ☐ DC ☐ OT ☐ PT ☐ ATC ☐ MT ☐ ST ☐ Other

*Setting: Is this Home Care Setting? ☐ Yes ☐ No

Would you like to attach additional documents to this Clinical Submission?

Upload/View Documents

Upload Instructions

Is this an Administrative Correction to a Previous Submission? ☐

Provider Completes This Section

*Date you want THIS submission to begin:

mm/dd/yyyy

*Number of visits within next 90 days:

Submit a PSF Electronically – Administrative Corrections

After clicking the check box, you must select all applicable reasons for the correction.

You must also enter the Portal Confirmation Number (PCN) from the electronic confirmation page, or the submission number from the response letter of the submission you wish to correct.

Optum

WebAssist
Physical Health

[Physical Health Locations](#)

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Home

Member Eligibility

Submit a Clinical Sub

Clinical Sub Status

Submit a Claim

Claim Status

Patients

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

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R

S

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Test, Test 01/01/1962

Physical Health Provider Support

Click here for live chat >>

Patient Summary Form

Patient Information

Last Name: Test First Name: Test MI: Gender: M DOB: 01/01/1962

Address: 123 Test City: Test State: OR Zip: 97814

ID#: 1111111111 Health Plan: UnitedHealthcare Medicare Group Number:

Referral Information

Physician: (if applicable) Date Issued: (if applicable) mm/dd/yyyy Referral Number: (if applicable)

Provider Information

John Chiropractor, DC, MT, LAC Office Location: 999999 Test, Denver, CO - *****8984

*Credentials: ☐ MD/DO ☐ DC ☐ OT ☐ PT ☐ ATC ☐ MT ☐ ST ☐ Other

*Setting: Is this Home Care Setting? ☐ Yes ☐ No

Would you like to attach additional documents to this Clinical Submission?

Upload/View Documents

[Upload Instructions](#)

Is this an Administrative Correction to a Previous Submission? ☒

Please note: Do not submit clinical appeals through this process. Please review plan summary for more information.

*Check applicable reason(s) (must select at least one)

☐ Patient information ☐ Provider information ☐ Date you want the corrected submission to begin ☐ CMT code ☐ Diagnosis code

*Reference # (Confirmation, submission #) of incorrect submission:

Provider Completes This Section

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18

Submit a PSF Electronically – Functional Outcome Measure (FOM) Score

If you have calculated the patient’s current FOM, you can enter the score in the space provided.

To calculate a FOM score, click on the form that your patient has completed.

An electronic version of the form will open for you. Once complete, click the Calculate and Accept buttons.

Your score will be placed within the electronic form.

Optum

WebAssist
Physical Health

Physical Health Locations

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Member Eligibility

Submit a Clinical Sub

Clinical Sub Status

Submit a Claim

Claim Status

Patients

A

B

C

D

E

F

G

H

I

J

K

L

M

N

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P

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X

Y

Z

Test Test

01/01/1902

Physical Health Provider Support

Click here for live chat »

Patient Summary Form

Patient Information

Last Name: Text First Name: Text MI: Gender: M DOB: 01/01/1902

Address: 123 Test City: Text State: OR Zip: 97814

ID# 1111111111 Health Plan: UnitedHealthcare Medicare Group Number:

Referral Information

Physician: Date Issued: mm/dd/yyyy Referral Number:

(if applicable) (if applicable) (if applicable)

Provider Information

Nature of Condition:

☐ 1-Initial onset (within last 3 months) ☐ 2-Recurrent (multiple episodes of < 3 months) ☐ 3-Chronic (continuous duration > 3 months)

*Cause of Current Episode:

☐ Traumatic ☐ Unspecified ☐ Repetitive ☐ Post-surgical ☐ Work related ☐ Motor vehicle

*Anticipated CMT Level:

☐ 98940 ☐ 98941 ☐ 98942 ☐ 98943 ☐ None

*Diagnosis (ICD code):

Dx1 Dx2 Dx3 Dx4

Dx5 Dx6 Dx7 Dx8

Dx9 Dx10 Dx11 Dx12

*Nature of Treatment:

Please select

Current Functional Measure Score:

Neck Index: Neck Form Back Index: Back Form ☐ N/A

DASH: DASH Form LEFS: LEFS Form ☐ ☐

(Other)

Neck Index

Pain Intensity

No Answer

Sleeping

No Answer

Reading

No Answer

Concentration

No Answer

Work

No Answer

Personal Care

No Answer

Lifting

No Answer

Driving

No Answer

Recreation

No Answer

Headaches

No Answer

1 Calculate

2 Accept

Clear Data

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19

Submit a PSF Electronically – Submit

When the electronic form is complete, click the ‘Submit’ button.

If you have forgotten to fill out any required information the site will prompt you to complete that question.

Optum

WebAssist
Physical Health

Physical Health Locations

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Home

Member Eligibility

Submit a Clinical Sub

Clinical Sub Status

Submit a Claim

Claim Status

Patients

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

X

Y

Z

Test Test

Physical Health Provider Support

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Patient Summary Form

The following errors must be corrected before submitting the form.

- Indicate if Home Care setting
- Primary Diagnosis Code not entered

Patient Information

Last Name: Test

First Name:

MI:

Gender:

DOB:

Address:

City:

State:

Zip:

ID#

Health Plan:

Group Number:

Referral Information

1 - No 2 - Yes

8. In general have you stopped enjoying all the things you usually enjoy?

1 - No 2 - Yes

9. Overall, how bothersome has your back pain been in the last 2 weeks?

1 - Not at all 2 - Slightly 3 - Moderately 4 - Very Much 5 - Extremely

Calculate Clear Data

*SBST Category: High Risk

© Originally Developed by: Keele University 01/08/07 Funded by Arthritis Research UK

Submit

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20


Submit a PSF Electronically – Confirmation Page

You will then receive a confirmation page that will include the information you submitted electronically on the PSF, along with your Confirmation Number.

You can write this number down as confirmation that we have received your submission or print the page.

If you scroll to the bottom of the Confirmation Page, you will see a 'Print Page' hyperlink.

Once you click this link, you can either download or print this page for your records.



WebAssist
Physical Health

Physical Health Locations

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Home

Member Eligibility

Submit a Clinical Sub

Clinical Sub Status

Submit a Claim

Claim Status

Patients

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W


X

Y

Z

Test, Test

Physical Health Provider Support



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Patient Summary Form Confirmation Page

Confirmation Number: 23179498

Patient Information

Last Name: Test First Name: Test Gender: M Date of Birth:

Address: City: State: Zip:

ID#: 1 Health Plan: e Group Number:

Provider Information

Provider Name:

Office Location:

Credentials:

Setting: Is this Home Care Setting?

Would you like to attach additional documents to this Clinical Submission? N
No documents were attached to this submission.

Do you feel that your back pain is terrible and it's never going to get any better: Y

In general have you stopped enjoying all the things you usually enjoy: Y

Overall, how bothersome has your back pain been in the last 2 weeks: 5-Extremely

SBSI Category: High Risk

Print Page

** Please print this page for your records

Submit a PSF Electronically – Checking Authorization Status

If there are no issues with the submission, it will take 24-48 business hours to process.

If there are any issues with your submission, Optum will contact you via phone or mail.

To check the status of your submission, go to the Optum WebAssist home page. Under the Activity Center, click the ‘Check Status’ hyperlink under Clinical Submissions.

Welcome, John Chiropractor, DC,MT,LAC, Tier 2

Links Help Sign Out

Optum

WebAssist
Physical Health

Physical Health Locations

Clinical Subs & Claims Tools & Resources Clinical Resources Home

Activity Center

Clinical Submissions and Claims

Clinical Submissions

Submit

Check Status

Claims

Submit

Check Status

Informational Center

Pediatric therapies (OT/PT) Clinical Review Faxing Process - UHC Commercial plan only

Reminder Notification: Provider Tier Letters Now Online!

Effective January 1, 2022, all Providers need to update their CAQH Profile on a regular basis

Submit a PSF Electronically – Checking Authorization Status

Upon clicking the ‘Check Status’ hyperlink under Clinical Submissions, you will be presented with a list of all your recent submissions.

If you chose to narrow your search results by selecting an Office Location, Decision Date, or Patient & Date of Birth information, you will then need to click the ‘Search’ button to view the results.

Optum

WebAssist
Physical Health

Physical Health Locations

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Home

Member Eligibility

Submit a Clinical Sub

Clinical Sub Status

Submit a Claim

Claim Status

Patients

A B C D E F

G H I J K L

M N O P Q R

S T U V W X

Y Z

Test, Test

Physical Health Provider Support

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Use the date range shown to find the applicable clinical submission - if the Status indicates Completed, click on Completed for more details.

Currently Selected Patient :None
Currently Selected Date :Last 1 month(s)

Search Options

Office Location :
--SELECT--

Optum Decision Date :
LAST 30 DAYS

Patient & Date of Birth :
Select Patient(s)

Search

Please Note:

Response Letters will be available online for 12 months after Optum Decision Date.

Clinical submissions on file for the last 30 days:

Confirmation #	Reference #	Patient Name	Date of Birth	Requested From	Status	Letter	Letter Uploaded on (CST)	Attachments
		Test, Test		03/25/2024	In Process	Not Available Online	NA	View
		Test, Test		03/13/2024	Completed	Open Letter	03/13/2024 17:58:33	View

Showing 1 - 2 of 2

Page 1 of 1

In Process

We have received your Clinical Submission. Please allow time for processing.

Completed

We have completed the review on your Clinical Submission.

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23

Submit a PSF Electronically – Checking Authorization Status

To view additional details, you can click the hyperlink within the ‘Status’ section of the search results.

If a submission is in process, you will receive a short summary page. You can either download or print this page for your records.

Optum

WebAssist
Physical Health

Physical Health Locations

Patients

A B C D E F

G H I J K L

M N O P Q R

S T U V W X

Y Z

Test,Test

01/01/1962

Physical Health Provider Support

Click here for
live chat >>

Member Eligibility

Use the date range shown to find the applicable clinic
Status indicates Completed, click on Completed for more details

Search Options

Office Location :
--SELECT--

Optum Decision Date
LAST 30 DAYS

Please Note:

Response Letters will be available online

Clinical submissions on file for the last 30 days:

Confirmation #	Reference #	Patient Name	Date of Birth	Requested From	Status	Letter	Letter Uploaded on (CST)	Attachments
		Test, Test		03/25/2024	In Process	Not Available Online	NA	View
		Test, Test		03/13/2024	Completed	Open Letter	03/13/2024 17:58:33	View

Showing 1 - 2 of 2

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Home

In-process Auth Status - Work - Microsoft Edge

about:blank

Recently Submitted Clinical Submission In Process

Provider: John Chiropractor, DC,MT,LAC

Patient Name: Test, Test

Confirmation #:

Requested From: 3/25/2024 12:00:00 AM

Clinical Submission Received on: 3/26/2024 12:00:00 AM

Requested Duration: weeks

Print Page

Confirmation #	Reference #	Patient Name	Date of Birth	Requested From	Status	Letter	Letter Uploaded on (CST)	Attachments
		Test, Test		03/25/2024	In Process	Not Available Online	NA	View
		Test, Test		03/13/2024	Completed	Open Letter	03/13/2024 17:58:33	View

Showing 1 - 2 of 2

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24

Submit a PSF Electronically – Checking Authorization Status

If a submission is completed, you will receive a summary page with important information regarding your submission.

You can either download or print this page for your records.

You can also view the determination letter associated with the notification. This can also be downloaded or printed for your records.

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WebAssist
Physical Health

Physical Health Locations

Member Eligibility

Patients

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

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Y

Z

Test Test

01/01/1962

Physical Health Provider Support

Click here for live chat

Use the date range shown to find the authorization status. Status indicates Completed, click on Confirmation # to view details.

Search Options

Office Location :
--SELECT--

Optum
LAST

Please Note: Response Letters will be emailed to the member's email address.

Clinical submissions on file for the last 12 months.

Confirmation #	Reference #	Patient	01/01/1962	03/13/2024	Completed	Open Letter	03/13/2024 17:58:33	View
23179498	29176582	Test,						
23153849	29153912	Test, Test						

Showing 1 - 2 of 2

Page 1 of 1

In Process

We have received your Clinical Submission. Please allow time for processing.

Completed

We have completed the review on your Clinical Submission.

about:blank - Work - Microsoft Edge

about:blank

Clinical Submission Response Details

Patient Name: Test Test

Health Plan: UnitedHealthcare Medicare

Provider: John Chiropractor, DC

Response #:

Clinical Submission Received on: 3/13/2024

Support Clinician: Administrative Review

You Requested:	Care From	Care Thru	Exams	CMT	Modalities / Procedures	X-rays	Supplies / Other
	3/13/2024		0	0	0	0	0
We Approved:	3/13/2024	3/13/2024>	0	0	0	0	0

The following actions and comments apply to this request:

The provider is not a participating provider with this health plan on this date of service. You are not required to submit clinical submission forms for this patient's group.

This does NOT constitute a guarantee of payment and is subject to benefit limits and member eligibility. This page is intended to be a brief summary of Optum's review for this patient. Please refer to the Clinical Submission Response letter for the final determination and complete information.

Print Page

Question On This Response

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25

For technical questions, issues, or concerns regarding our website, email us from the home page.

Click the hyperlink under 'Encountered a Problem?' in the Activity Center.



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