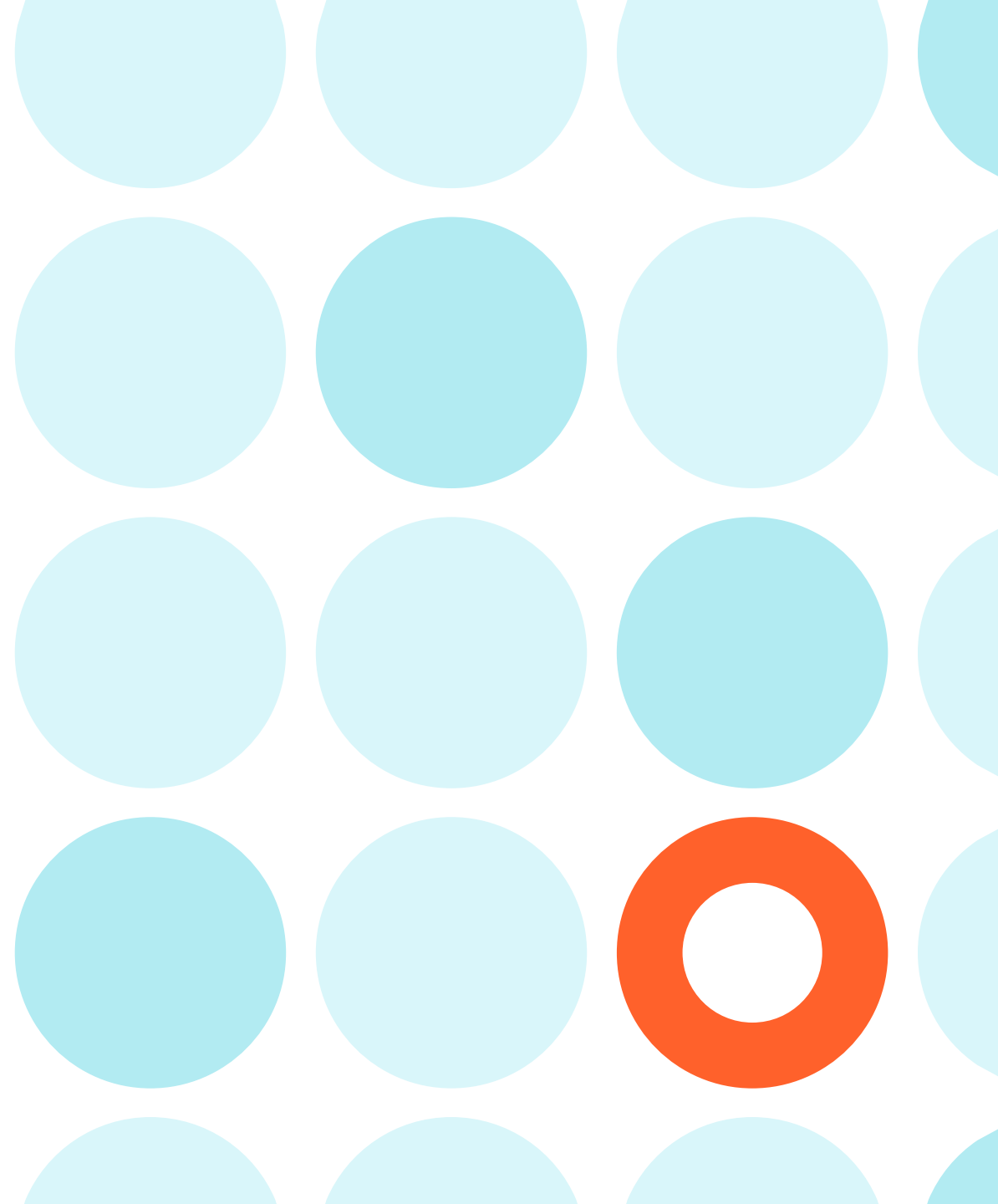




# Welcome to WebAssist Optum Provider Portal

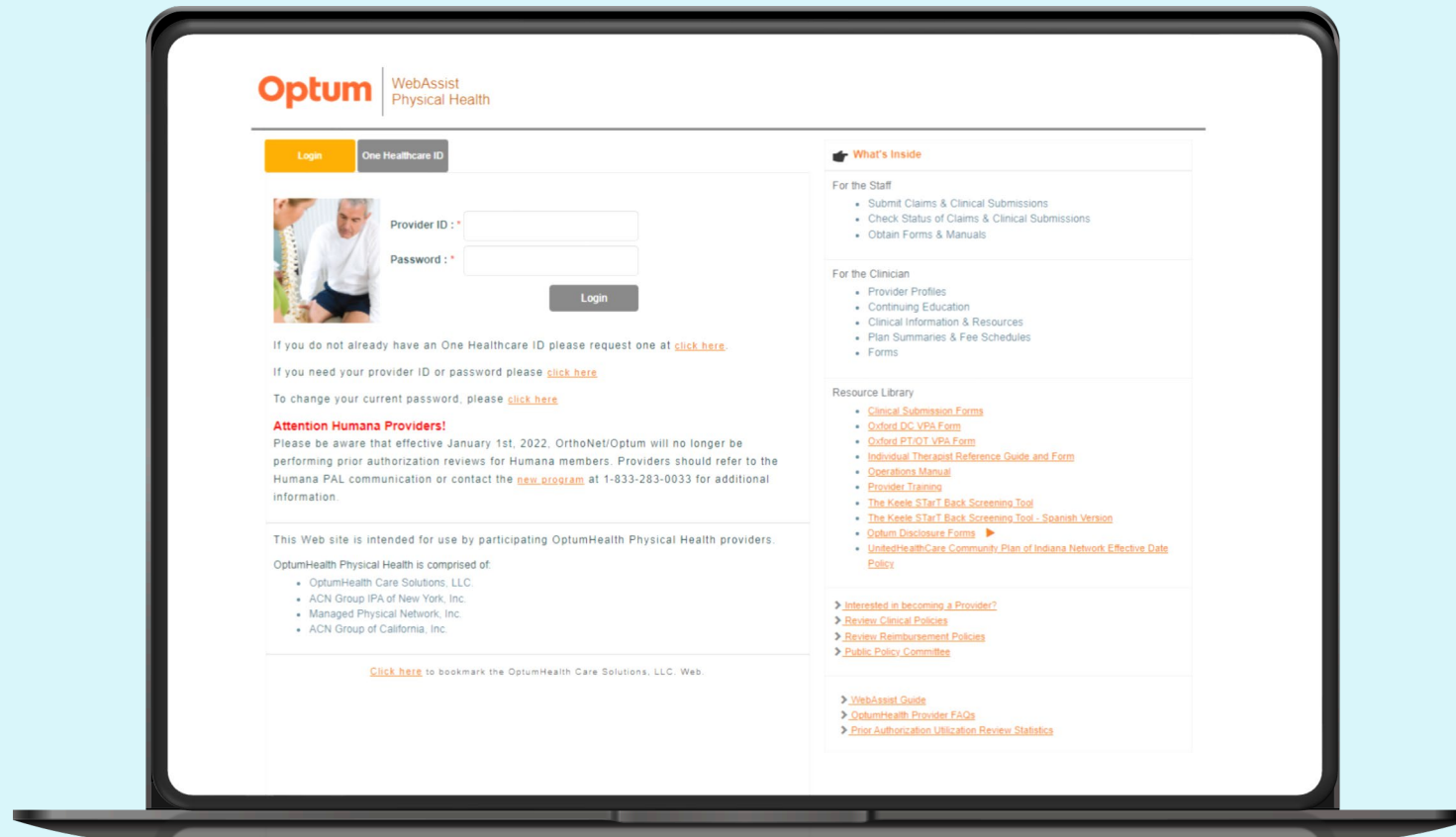
**Discover How to Submit a PSF-750 Online**

**Published February 2025**



# 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.



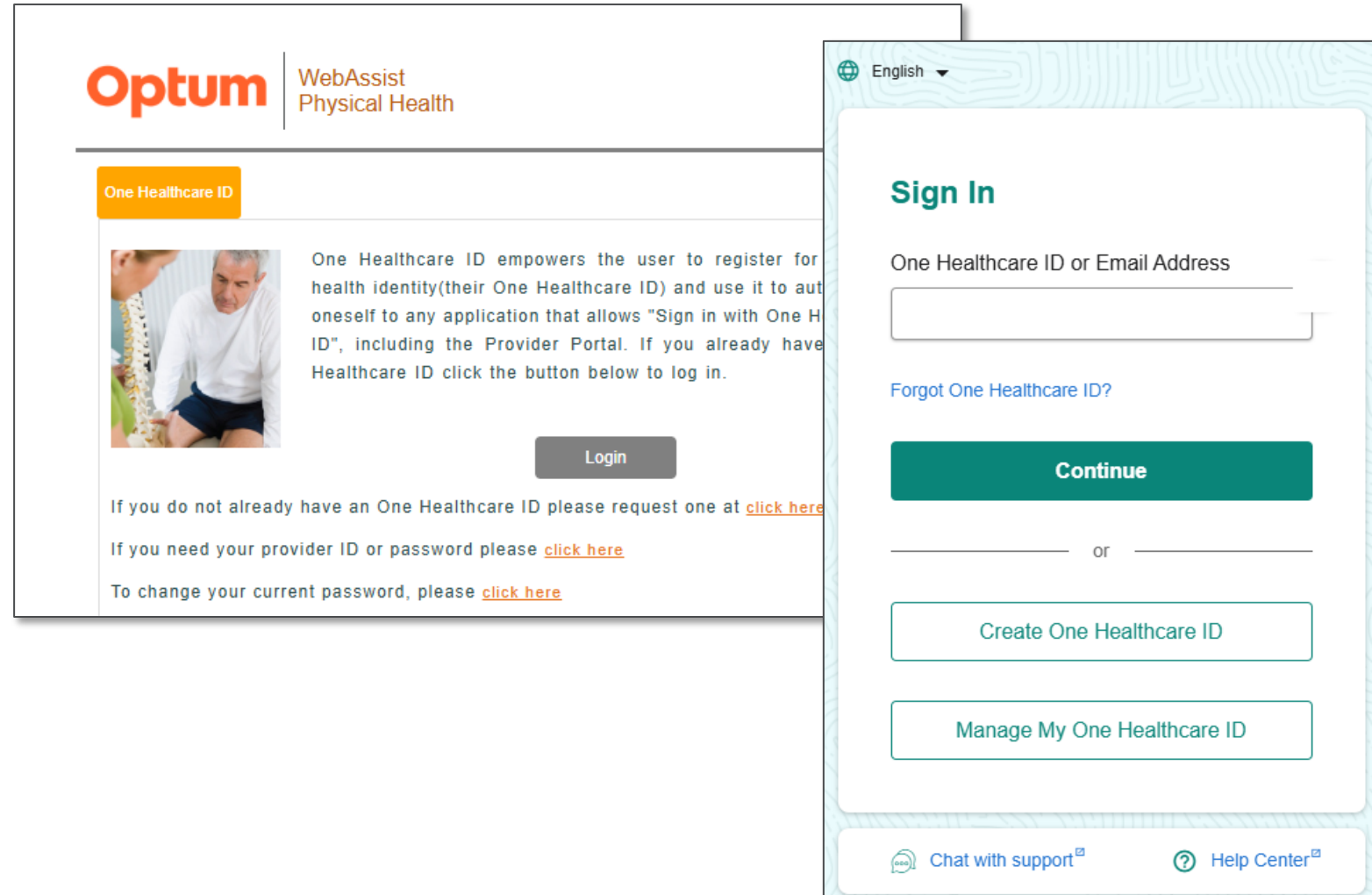
## Index

- 4** Login Instructions
- 5-6** Determine if Clinical Submission is Required – UHC Medicare Members
- 7** Member Eligibility and Benefits
- 8-14** Enter a PSF-750 Electronically
- 15-16** Enter a PSF-750 Electronically – Medicare Addendum
- 17-18** Administrative Corrections
- 19** Current Functional Measure Score
- 20-21** Submit
- 22** Confirmation Page
- 23-26** Authorization Status Check
- 27** Technical Assistance

# Login Using Your One Healthcare ID and Password

Once you click the 'Login' button, you will be prompted with the One Healthcare login page. Follow login instructions using your OneHealthCare ID and Password.

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



**Optum** | WebAssist  
Physical Health

**One Healthcare ID**

One Healthcare ID empowers the user to register for health identity(their One Healthcare ID) and use it to authenticate themselves to any application that allows "Sign in with One Healthcare ID", including the Provider Portal. If you already have a One Healthcare ID click the button below to log in.

[Login](#)

If you do not already have an One Healthcare ID please request one at [click here](#)

If you need your provider ID or password please [click here](#)

To change your current password, please [click here](#)

**Sign In**

One Healthcare ID or Email Address

[Forgot One Healthcare ID?](#)

[Continue](#)

or

[Create One Healthcare ID](#)

[Manage My One Healthcare ID](#)

[Chat with support](#) [Help Center](#)

# 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 'UHC Medicare Quick Group Check.'

\*Excludes UnitedHealthcare Medicare Solutions West

Optum

WebAssist  
Physical Health

Physical Health Locations

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Credentialing Application Status

Home

Activity Center

Clinical Submissions and Claims

Clinical Submissions	Claims
<a href="#">Submit</a>	<a href="#">Submit</a>
<a href="#">Check Status</a>	<a href="#">Check Status</a>

Recent Clinical Submissions

There are 21 recently submitted clinical submissions and 6 clinical submissions completed in the last 2 weeks.

[See Recent Clinical Submissions](#)

Expiring Clinical Submissions

There is 1 clinical submission expiring within the next 10 days.

[See Expiring Clinical Submissions](#)

Patient Status Report

[Click here to complete PSR](#)

Encountered a problem ?

[Click here to get assistance](#)

Informational C

Informational

Medicare User G

Effective January

Guide to Comple

Network News

Operations Manuals

Plan Summaries

Fee Schedules

State Regulatory Addendums

Medicare User Guide

Patient Satisfaction Result

Patient Satisfaction CAHPS

Tutorial

CAHPS Survey Methodology

Forms

Patient Status Report Reference

Guide

Electronic Claims

UHC Quick Group Check

UHC Medicare Quick Group Check

Reimbursement Policies

California Language Assistance

Information

CMS Fraud, Waste & Abuse

Provider Training

Download 835 Electronic

Remittance Advice File

to update their CAQH Profile on a regular

tion Clinical, Claims, Progress Notes

Optum

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5

# Determine if Clinical Submission is Required

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

**Optum**

WebAssist  
Physical Health

Physical Health Locations

Network News

Operations Manuals

Plan Summaries

Fee Schedules

State Regulatory Addendums

Medicare User Guide

Patient Satisfaction Result

Patient Satisfaction CAHPS Tutorial

CAHPS Survey Methodology

Forms

Patient Status Report Reference Guide

Electronic Claims

UHC Quick Group Check

UHC Medicare Quick Group Check

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Credentialing Application Status

Home

UHC Medicare Quick Group Check

Clinical submission requirements differ by member groups. 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 letter (example: 3U585). For other Groups, please contact UnitedHealthcare customer service 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'.

Select the Health Plan from the dropdown menu, enter the member's information, then click 'search.'

The screenshot displays the Optum WebAssist Physical Health interface. The top navigation bar includes a welcome message for John Chiropactor, DC, MT, LAC, Tier 2, and links for Help and Sign Out. The main menu on the left lists 'Physical Health Locations', 'Activity Center', 'Clinical Submissions and Claims', and 'Informational Center'. The 'Clinical Submissions and Claims' section is expanded, showing 'Clinical Submissions' and 'Claims' with 'Submit' and 'Check Status' links. The 'Informational Center' section is also expanded, showing 'Pediatric therapies (OT)', 'Reminder Notification: Provider T', and 'Effective January 1, 2022, all Provi'. The 'Member Eligibility' link is highlighted in the 'Clinical Subs & Claims' menu. The 'Member Eligibility' form is shown, featuring a 'Health Plan' dropdown menu (labeled 3), 'Last Name', 'First Name', 'ID', 'DOB', and 'Group Number' fields. The 'Find Member' and 'Clear' buttons are at the bottom. The 'Patients' section on the left shows a grid of letters (A-Z) and a 'Test, Test' button. The 'Member Search' section on the right shows a 'Search By' dropdown with 'Subscriber /Member ID' selected, and fields for 'Subscriber/Member ID', 'Last Name', 'First Name', 'Date Of Birth', and 'Group ID'. The 'Show' section has 'Active Members Only' selected. The 'Clear', 'Search', and 'Back' buttons are at the bottom.

# 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.

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

Links Help Sign Out

Optum WebAssist Physical Health

Physical Health Locations

Activity Center

Clinical Submissions and Claims

Clinical Submission

Submit

Check Status

Recent Clinical Su

There are no recent submissions and 1 completed in the la

See Recent Clinical

Informational Center

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

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Home

About Clinical Resources

Clinical Guidelines

Clinical Forms

Patient Status Report Reference Guide

Optum WebAssist Physical Health

Physical Health Locations

Clinical Subs & Claims

Tools & Resources

Clinical Resources

Home

Clinical Forms

Based upon the process designated in the Plan Summary, please choose the appropriate set of forms.

3

Fax Cover Sheet

Patient Summary Form Quick Reference Guide

Patient Summary Form PSF-750

Patient Summary Form PSF-750 - Chinese Version

Patient Summary Form PSF-750 - Spanish Version

Disabilities of the Arm, Shoulder and Hand (DASH)

Scoring the DASH

Disabilities of the Arm, Shoulder and Hand (DASH) - Spanish Version

Lower Extremity Functional Scale (LEFS)

Scoring the LEFS

Lower Extremity Functional Scale (LEFS) - Spanish version

Back Index

Back Index - Spanish Version

Neck Index

Using Neck Back Outcome Tools

Neck Index - Spanish Version

UHC Clinical Submission Process Guide

The Keele STarT Back Screening Tool

Category Description

The Keele STarT Back Screening Tool - Spanish Version



# 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

Optum

WebAssist  
Physical Health

Physical Health Locations

Clinical Subs & Claims Tools & Resources

Activity Center

Clinical Submissions and Claims

Clinical Submissions

Submit

Check Status

Claims

Submit

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 – 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 plans<sup>1</sup>, select UnitedHealthcare Medicare, For UnitedHealthcare Medicare Solutions West<sup>2</sup> Select "United Healthcare Medicare Solutions West".

The screenshot displays the Optum WebAssist Physical Health interface. At the top, a navigation bar includes the Optum logo, 'WebAssist Physical Health', and a user welcome message: 'Welcome, John Chiropractor, DC, MT, LAC, Tier 2'. Below this is a menu with 'Physical Health Locations', 'Clinical Subs & Claims', 'Tools & Resources', 'Clinical Resources', 'Credentialing Application Status', and 'Home'. A secondary menu contains 'Member Eligibility', 'Submit a Clinical Sub', 'Clinical Sub Status', 'Submit a Claim', and 'Claim Status'.

The 'Patients' section features a grid of letters (A-Z) for patient selection. Below the grid, there is a 'Test Test' button and a 'Physical Health Provider Support' link with a 'Click here for live chat' button.

The 'Plan' section is highlighted with a red box and a red arrow pointing to the 'Please select' dropdown menu. To the right of the dropdown, two example member cards are shown, labeled '1' and '2'.

**Member Card 1 (UnitedHealthcare UCard):**

- MEMBER A SAMPLE**
- Member ID: 123456789-00
- UHC Dual Complete ME-S001 (PPO D-SNP)
- With Dental
- RxBIN: 610097, RxPCN: 9999, RxGRP: COS
- Group Number: 44509 H0271-006-000
- PCP: PROVIDER
- PCP: 555-555-5555

**Member Card 2 (UnitedHealthcare UCard):**

- MEMBER A SAMPLE**
- Member ID: 123456789-01
- AARP Medicare Advantage from UHC CA-0001 (HMO-POS)
- With Dental
- RxBIN: 610097, RxPCN: 9999, RxGRP: SHCA
- Group Number: HCF4V4-1G4 H0543-013-000
- PCP: PROVIDER
- PCP: 555-555-5555
- FACILITY NAME SAMPLE
- PCP \$20 Spec \$40

Both cards include a 'Printed: 09-28-2023' date, a 'Rewards' section, and a barcode. The bottom of the cards lists contact information for providers, dental services, medical claims, and pharmacy services.

# 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, first select the plan name, and then complete 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 member search**.

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

The screenshot displays the Optum WebAssist Physical Health interface. At the top, the Optum logo is followed by 'WebAssist Physical Health'. Below this is a navigation bar with links: 'Physical Health Locations', 'Clinical Subs & Claims' (highlighted), 'Tools & Resources', 'Clinical Resources', 'Credentialing Application Status', and 'Home'. A secondary navigation bar contains 'Member Eligibility', 'Submit a Clinical Sub', 'Clinical Sub Status', 'Submit a Claim', and 'Claim Status'. The main content area is divided into two sections. On the left, under the heading 'Patients', there is an alphabetical grid of letters (A-Z) with the letter 'T' highlighted. Below the grid is a search bar containing 'Test,Test' and a date field '01/01/1962'. A red arrow points from the 'T' in the grid to the search bar. Below the search bar is a 'Physical Health Provider Support' button with a 'Click here for live chat' link. On the right, under the heading 'Plan:', there is a dropdown menu showing 'UnitedHealthcare Medicare'. Below this is a 'Member Search' section with a red star icon and the text 'Required'. The search section includes a 'Search By:' dropdown with 'Subscriber /Member ID' selected, and a radio button for 'Last Name'. Below this is a note: 'Subscriber ID Only OR Subscriber ID + Any Other Optional Field(s)'. The search fields include 'Subscriber/Member ID\*' (with a red star), 'Last Name', 'First Name', 'Date Of Birth' (with a date format hint 'mm/dd/yyyy'), and 'Group ID'. Below the search fields is a 'Show:' section with a radio button for 'Active Members Only' and a radio button for 'All Members'. At the bottom of the search section are three buttons: 'Clear', 'Search', and 'Back'.

# Submit a PSF electronically – Patient Information – Group Number

After selecting an existing member, or the search returns a member, if the member's group requires submission, you will receive a message that clinical submission is required and will be prompted to complete the Patient Type questions and select the office location for the submission.

If the group does NOT require submission, you will receive a message that clinical submission is not required, and no office locations will populate. You will be unable to move forward with the submission process.



Click here for live chat

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.

Last Name

First Name

MI

Gender

DOB (mm/dd/yyyy)

ID#

Address

City

State

Zip

Group Number

Please enter the 5 digit group number.

\*Patient Type:

☐ 1-New to your office ☐ 2-Est'd, new condition ☐ 3-Est'd, gap in care >= 90 days ☐ 4-Est'd, continuing care

\*Date you want THIS submission to begin: mm/dd/yyyy

Clinical Information

Office Location with TIN number

Please select your Clinic Address

Clinical submission is required for Group 74204 members.

Clinical submission is not required for Group 00700.

gent care definition is met. Care may qualify as mination could seriously jeopardize the life or A determination for urgent care will be issued

the applicable Plan Summary. Providers may call nt care.

Address

3571 YORKSHIRE CIRCLE

City

CROMWELL

State

IN

Zip

46732

## Submit a PSF electronically – Patient Information – Patient Type

If you answer that your patient meets the condition of options 1, 2, or 3, you will need to certify that the patient's clinical records support the "Patient Type" and indicate if you are requesting less than or equal to six visits over less than or equal to eight weeks.

Once complete, select your office location and the remainder of the electronic PSF-750 will display.

[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  
☐ Male ☒ Female

DOB (mm/dd/yyyy)

ID#

Address

City

State

Zip

Group Number

Please enter the 5 digit group number.

\*Patient Type:  
☒ 1-New to your office ☐ 2-Est'd, new condition ☐ 3-Est'd, gap in care >= 90 days ☐ 4-Est'd, continuing care

\*Date you want THIS submission to begin:  mm/dd/yyyy

☒ I certify that the patient's clinical records support the "Patient Type"

Are you requesting ≤ 6 visits over ≤ 8 weeks ☒ Yes ☐ No

Clinical Information

Office Location with TIN number

## Submit a PSF Electronically – Clinical Information

Based upon your selections from the previous page, you will be presented with the appropriate intake questions.

Enter all required the clinical information within the electronic form.

Patients		Member Eligibility   Submit a Clinical Sub   Clinical Sub Status   Submit a Claim   Claim Status																									
<p><b>Test Test</b> 01/01/1962</p> Click here for live chat >>																											
<h3>Patient Summary Form</h3> <div style="border: 1px solid #ccc; padding: 10px;"> <h4>Patient Information</h4> <p>Last Name: [Text] First Name: [Text] MI: [Text] Gender: F DOB: [Text]</p> <p>Address: [Text] City: [Text] State: VT Zip: [Text]</p> <p>ID#: [Text] Health Plan: UnitedHealthcare Medicare Group Number: 74204</p> <hr/> <h4>Referral Information</h4> <p>Physician: [Text] Date Issued: [Text] mm/dd/yyyy Referral Number: [Text] <small>(if applicable) (if applicable)</small></p> <p>*Date you want THIS submission to begin: 02/14/2025 mm/dd/yyyy *Patient Type: 1-New to your office</p> <hr/> <h4>Provider Information</h4> <p>John Chiropractor, DC, MT, LAC Office Location: 4700 Main, Buck Creek Mg Road Stg. IN - *****9993</p> <p>*Auth Type Submitting for/Credentials: MD/DO DC OT PT ATC MT ST Other [Text]</p> <p>*Place of Service  <input type="radio"/> 11-Office - Outpatient <input type="radio"/> 19-Off-Campus Outpatient Hospital <input type="radio"/> 22-Hospital - Outpatient <input type="radio"/> 24-Outpatient Facility <input type="radio"/> Other </p> <p>Provider Office Contact Information for This Submission</p> <p>*Phone number: 1234567889 Tap Phone number box to edit it Staff Contact Name: John</p> <hr/> <h4>Provider Completes This Section</h4> <p>*Diagnosis (ICD code):</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td>Dx1</td><td>Dx2</td><td>Dx3</td><td>Dx4</td></tr> <tr> <td>[Text]</td><td>[Text]</td><td>[Text]</td><td>[Text]</td></tr> <tr> <td>Dx5</td><td>Dx6</td><td>Dx7</td><td>Dx8</td></tr> <tr> <td>[Text]</td><td>[Text]</td><td>[Text]</td><td>[Text]</td></tr> <tr> <td>Dx9</td><td>Dx10</td><td>Dx11</td><td>Dx12</td></tr> <tr> <td>[Text]</td><td>[Text]</td><td>[Text]</td><td>[Text]</td></tr> </table> <div style="margin-top: 10px;"> <input type="checkbox"/> I hereby attest that the information provided in this submission is accurate and complete to the best of my knowledge. I understand that any inaccuracies or omissions may affect the processing of this submission. </div> <div style="text-align: right; margin-top: 10px;"> <span style="background-color: #ccc; padding: 5px 15px; cursor: pointer;">Submit</span> </div> </div>				Dx1	Dx2	Dx3	Dx4	[Text]	[Text]	[Text]	[Text]	Dx5	Dx6	Dx7	Dx8	[Text]	[Text]	[Text]	[Text]	Dx9	Dx10	Dx11	Dx12	[Text]	[Text]	[Text]	[Text]
Dx1	Dx2	Dx3	Dx4																								
[Text]	[Text]	[Text]	[Text]																								
Dx5	Dx6	Dx7	Dx8																								
[Text]	[Text]	[Text]	[Text]																								
Dx9	Dx10	Dx11	Dx12																								
[Text]	[Text]	[Text]	[Text]																								
<h3>Referral Information</h3> <p>Last Name: [Text] First Name: [Text] MI: [Text] Gender: [Text] DOB: [Text]</p> <p>Address: [Text] City: LI State: [Text] Zip: [Text]</p> <p>ID# [Text] Health Plan: UnitedHealthcare Medicare Group Number: [Text]</p> <hr/> <h3>Referral Information</h3> <p>Physician: [Text] Date Issued: [Text] mm/dd/yyyy Referral Number: [Text] <small>(if applicable) (if applicable)</small></p>																											
<h3>Provider Information</h3> <p>John Chiropractor, DC, MT, LAC Office Location: 4700 Main, Buck Creek Mg Road Stg. IN - *****9993</p> <p>*Auth Type Submitting for/Credentials: MD/DO DC OT PT ATC MT ST Other [Text]</p> <p>*Place of Service  <input type="radio"/> 11-Office - Outpatient <input type="radio"/> 19-Off-Campus Outpatient Hospital <input type="radio"/> 22-Hospital - Outpatient <input type="radio"/> 24-Outpatient Facility <input type="radio"/> Other </p> <p>Provider Office Contact Information for This Submission</p> <p>*Phone number: 1234567889 Tap Phone number box to edit it Staff Contact Name: John</p>																											
<p>Would you like to attach additional documents to this Clinical Submission? <span style="background-color: #ccc; padding: 2px 10px; font-size: small;">Upload/View Documents</span> <a href="#" style="font-size: small; color: #007bff;">Upload Instructions</a></p> <hr/> <p><b>Is this an Administrative Correction to a Previous Submission?</b> <input type="checkbox"/></p>																											
<h3>Provider Completes This Section</h3> <p>*Date you want THIS submission to begin: 02/14/2025 mm/dd/yyyy *Number of visit(s) within past 90 days: [Text]</p> <p><input checked="" type="checkbox"/> For UHC Medicare members, a request for six (6) visits or less, over eight (8) weeks or less, is eligible for administrative approval under the following conditions:</p> <ul style="list-style-type: none"> <li>The member is new to your office.</li> <li>The member presents with a new condition.</li> <li>The member has had a gap in care of 90 or more days.</li> </ul> <p>Please note that this approval is pending member eligibility verification. Additionally, any treatment needs beyond the approved service levels will require a clinical submission for further review. Date extensions and modifications to this approval are not permitted.</p> <p>*Requested duration in weeks: [Text] *Requested number of visits: [Text]</p> <p>*Patient Type: 4-Est'd, continuing c</p> <p>*Nature of Condition:  <input type="radio"/> 1-Initial onset (within last 3 months) <input type="radio"/> 2-Recurrent (multiple episodes of &lt; 3 months) <input type="radio"/> 3-Chronic (continuous duration &gt; 3 months) </p> <p>*Cause of Current Episode:  <input type="checkbox"/> Traumatic <input type="checkbox"/> Unspecified <input type="checkbox"/> Repetitive <input type="checkbox"/> Post-surgical <input type="checkbox"/> Work related <input type="checkbox"/> Motor vehicle </p> <p>*Anticipated CMT Level:  <input type="checkbox"/> 98940 <input type="checkbox"/> 98941 <input type="checkbox"/> 98942 </p> <p>*Diagnosis (ICD code):</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td>Dx1</td><td>Dx2</td><td>Dx3</td><td>Dx4</td></tr> <tr> <td>[Text]</td><td>[Text]</td><td>[Text]</td><td>[Text]</td></tr> </table> <p style="text-align: right;"><small>*Nature of Treatment:</small></p>				Dx1	Dx2	Dx3	Dx4	[Text]	[Text]	[Text]	[Text]																
Dx1	Dx2	Dx3	Dx4																								
[Text]	[Text]	[Text]	[Text]																								

# 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**

John Chiropractor, DC, MT, LAC Office Location: 4700 Main, Buck Creek Mg Road Stg, IN - \*\*\*\*\*9993

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

**\*Place of Service**

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

**Provider Office Contact Information for This Submission**

\*Phone number: 1234567889 Tap Phone number box to edit it Staff Contact Name: John

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: 02/14/2025 mm/dd/yyyy \*Number of visit(s) within past 90 days:

**For UHC Medicare members, a request for six (6) visits or less, over eight (8) weeks or less, is eligible for administrative approval under the following conditions:**

- The member is new to your office.
- The member presents with a new condition.
- The member has had a gap in care of 90 or more days.

Please note that this approval is pending member eligibility verification. Additionally, any treatment needs beyond the approved service levels will require a clinical submission for further review. Date extensions and modifications to this approval are not permitted.

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

\*Patient Type: 4-Est'd. continuing c

**\*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**

John Chiropractor, DC, MT, LAC Office Location: 4700 Main, Buck Creek Mg Road Ste. IN - \*\*\*\*\*9993

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

\*Place of Service

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

**Provider Office Contact Information for This Submission**

\*Phone number: 1234567889 Tap Phone number box to edit it Staff Contact Name: John

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: 02/14/2025 mm/dd/yyyy \*Number of visit(s) within past 90 days:

☒ For UHC Medicare members, a request for six (6) visits or less, over eight (8) weeks or less, is eligible for administrative approval under the following conditions:

- The member is new to your office.
- The member presents with a new condition.
- The member has had a gap in care of 90 or more days.

Please note that this approval is pending member eligibility verification. Additionally, any treatment needs beyond the approved service levels will require a clinical submission for further review. Date extensions and modifications to this approval are not permitted.

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

\*Patient Type: 4-Est'd, continuing c

\*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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Test, Test01/01/1962

Physical Health Provider Support

Click here for live chat >>

Patient Summary Form

Patient Information

Last Name:TestFirst Name:TestMI:Gender:MDOB:01/01/1962

Address:123 TestCity:TestState:ORZip:97814

ID#1111111111Health Plan:UnitedHealthcare MedicareGroup Number:

Referral Information

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

Provider Information

John Chiropractor, DC, MT, LACOffice 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:

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# 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.

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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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# 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.

\*If you don't have any functional score to provide, enter N/A in the "FOM Name" field

## Patient Summary Form

### Patient Information

Last Name:  First Name:  MI:  Gender:   
Address:  City:  State:  Zip:   
ID#:  Health Plan: UnitedHealthcare Medicare

### Referral Information

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

### Provider Information

John Chiropractor, DC, MT, LAC Office Location: 4700 Main, Buck Creek Mng Road Stg, IN - \*\*\*\*\*9993

### \*Anticipated CMT Level:

☐ 98940 ☐ 98941 ☐ 98942

### \*Diagnosis (ICD code):

Dx1	Dx2	Dx3	Dx4
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dx5	Dx6	Dx7	Dx8
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dx9	Dx10	Dx11	Dx12
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### Current Functional Measure Score:

Neck Index:  Neck Form Back Index:  Back Form  
DASH:  DASH Form LEFS:  LEFS Form  
FOM Name: N/A FOM Score:

\*Objective measurements identify impairments when they are compared to normal values, the uninjured control level of function.

## 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

Calculate Accept Clear Data

# Submit a PSF Electronically – Submit

When the electronic form is complete, and you have attested that all the information is correct, click the ‘Submit’ button.

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

Once complete, re-attest and click the ‘Submit’ button.

## Patients

A	B	C	D	E	F
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M	N	O	P	Q	R
S	T	U	V	W	X
Y	Z				

Test,Test 01/01/1962



## Patient Summary Form

The following errors must be corrected before submitting the form.

- Primary Diagnosis Code not entered
- Select a Nature of Treatment

## Patient Information

Last Name:	<input type="text"/>	First Name:	<input type="text"/>	MI:	<input type="text"/>	Gender:	<input type="text"/>	DOB:	<input type="text"/>
Address:	<input type="text"/>		City:	<input type="text"/>	State:	<input type="text"/>	Zip:	<input type="text"/>	
ID#:	<input type="text"/>	Health Plan:	UnitedHealthcare Medicare			Group Number:	74204		

## Referral Information

Physician:	<input type="text"/>	Date Issued:	<input type="text"/>	mm/dd/yyyy	Referral Number:	<input type="text"/>
------------	----------------------	--------------	----------------------	------------	------------------	----------------------

The SBST questionnaire isn't required for existing continuing care patients.

☐ I hereby attest that the information provided in this submission is accurate and complete to the best of my knowledge. I understand that any inaccuracies or omissions may affect the processing of this submission.

Submit

# Submit a PSF Electronically – Submit



Depending upon the information submitted while completing the PSF-750, you may receive a message that your submission has been automatically approved.

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Test Test01/01/1962

Patient Summary Form Confirmation Page

Confirmation Number: 24554365

Patient Information

Last Name:First Name:Gender:Date of Birth:  
Address:City:State:Zip:  
ID#:Health Plan: UnitedHealthcare MedicareGroup Number: 74204

Alert

Your request is approved for six (6) visits (98942 or 98941 or 98940), over eight (8) weeks. To request continuing care beyond this approval, clinical submission will be required. Date extensions and modification of this approval are not allowed.

OK

Provider Completes This Section

Date you want THIS submission to begin: 02/14/2025  
Patient Type: 1-New to your office  
Requested for ≤ 6 visits over ≤ 8 weeks: Yes  
Diagnosis (ICD code): m454

Print Page

\*\* Please print this page for your records

Response Notification

Your notification response letter for this request will be available online in accordance with applicable state notification timeframes.

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# 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.

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Test, Test

Physical Health Provider Support

Click here for live chat

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? I

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

SST Category: High Risk

Print Page

\*\* Please print this page for your records

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# 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

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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.

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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	<a href="#">View</a>
		Test, Test		03/13/2024	Completed	Open Letter	03/13/2024 17:58:33	<a href="#">View</a>

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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# 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.

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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	<a href="#">View</a>
		Test, Test		03/13/2024	Completed	Open Letter	03/13/2024 17:58:33	<a href="#">View</a>

Showing 1 - 2 of 2

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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	<a href="#">View</a>
		Test, Test		03/13/2024	Completed	Open Letter	03/13/2024 17:58:33	<a href="#">View</a>

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# 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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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	Start Date	End Date	Status	Action	Timestamp	View
23179498	29176582	Test,						
23153849	29153912	Test, Test	01/01/1962	03/13/2024	Completed	Open Letter	03/13/2024 17:58:33	View

Showing 1 - 2 of 2

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

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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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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