PT or OT Patient Progress Report

❑ Physical Therapy ❑ Occupational Therapy

Fax: (716) 857-6361 or 1(888) 465-1373 Questions: (716) 857-6303 or 1(888) 576-7783

Patient / Member Information		
Member Name :		Member ID No.
Diagnosis:		Plan *(select one)*: ❑ WNY ❑ CNY ❑ Univ. at Buffalo
ICD-9 Code:	Date of Initial PT/OT Visit:	Date of Surgery (if applicable):

Physical Therapist (PT) or Occupational Therapist (OT) Information			
PT/ OT Facility:		PT/OT Provider ID#:	
PT/OT Phone:		PT/OT Fax:	

✦ **FOR WOUND CARE, PLEASE SUBMIT A TYPEWRITTEN INITIAL EVALUATION AND UPDATED PROGRESS NOTE** ✦

		Additional Pertinent Information
Pain Level: *(circle one on each line)*	AT REST No pain 0 1 2 3 4 5 6 7 8 9 10 Excruciating	
	W/ MOVEMENT No pain 0 1 2 3 4 5 6 7 8 9 10 Excruciating	
Nature of Pain: *(check one)*	❑ Constant (76-100%) ❑ Frequent (51-75%) ❑ Occasional (26-50%) ❑ Intermittent (25% or less)	
Since treatment began, limitations have: ❑ Decreased ❑ Increased ❑ Remained the same		

Describe Current Complaint:

Joints with Limited ROM *(degrees or %)*			**Muscle Groups with Limited Strength**		**Treatment Goals**
Joint	*Passive R/L*	*Active R/L*	*Muscle Group*	*MMT Grade (0 to 5) R/L*	
	/	/		/	
	/	/		/	
	/	/		/	
	/	/		/	

Ability to Perform Daily Activities	*Check one box per activity*					
Activity	*Cannot Perform*	*Limited by Pain*	*Needs Assistance*	*Needs Device or Task Modification*	*Needs Excessive Time*	*Performs Normally*

Provider Signature:	Date:	# Visits Used to Date:

Utilization Review (*for Univera Use Only*)		
Criteria Met? ❑ Yes ❑ No (*If no, complete Reviewer Rationale*)		Reviewer Rationale:
# Additional Visits Authorized:	Total # Visits Authorized:	❑ Per Member's Contract : ❑ Coverage Limited to 2 months per condition ❑ Coverage limited to ______ days per year
Effective Referral Period:		❑ Insufficient information to justify request; please submit: ❑ Copy of evaluation ❑ All typed progress notes and measurable objective data ❑ Summary of progress over last two-week interval ❑ Updated physician script
Determined: ❑ Based on objective data provided Date:		❑ Referred for medical review

Authorization does not guarantee or confirm that benefits will be paid.
Payment of claims is subject to member eligibility and to contract limitations, provisions, and exclusions.

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