Please forward this form along with the physician's prescription.

Physical Therapy Pre-Certification Form
Additional Visits/Upper Extremity

QualCare, Inc.
30 Knightsbridge Road
Piscataway, NJ 08854-3754

Patient's Name: ID Number: Group:

Date of Birth: Age: Other Medical Insurance Yes ☐ No ☐

If yes, Name Policy Number:

If MVA/Other: Date Of Accident Ins. Name: Phone: Policy#

Date of Re-Evaluation Number of **Completed** Visits:

Primary symptoms:

Duration: Frequency: ☐ Constant ☐ Intermittent

Quality: ☐ Ache ☐ Burning ☐ Numbness ☐ Sharp ☐ Dull ☐ Spasm

Pain Level: (0-10) Current Best Worst Exacerbated by:

Onset Date: Injury due to: ☐ MVA ☐ WC ☐ Other N/A ☐

Upper Extremity

	(**Rt**) ROM Active	ROM Passive	MMT	(**Lt**) ROM Active	ROM Passive	MMT	
Shoulder Abduction							Functional Limits Mild ☐ Moderate ☐ Severe ☐
Adduction							
Internal Rotation							Adherence to HEP Yes ☐ No ☐
External Rotation							
Elbow Extension							
Flexion							
Forearm Supination							Improved ROM Yes ☐ No ☐
Pronation							Improved Functional Independence Yes ☐ No ☐
Wrist Flexion							Improved Strength Yes ☐ No ☐
Extension							
Ulnar Deviation							
Radial Deviation							

Additional Information/Special Testing/Deficits:

Diagnosis: (List by ICD 9 Code)

1.	2.	3.	4.

Goals	Short Term	Long Term
1.		1.
2.		2.
3.		3.
4.		4.

Provider: _____ **Tax ID Number:** _____

Phone Number: **Contact Name/ Fax Number:**

Pre-Certification Department (Phone) **Fax Number: 732-562-1023**

PPO 800-992-6613 **HMO Network 800-254-0130 (phone)**