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

Physical Therapy Pre-Certification Form
Initial /Lower 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 Initial Evaluation: Number of **Requested** 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 ☐

Lower Extremity

	(Rt) ROM Active	**ROM Passive**	**MMT**	**(Lt) ROM Active**	**ROM Passive**	**MMT**	
Hip Flexion							Functional Limits Mild ☐
Extension							Moderate ☐ Severe ☐
Abduction							HEP Initiated Yes ☐ No ☐
Adduction							Parethesis Yes ☐ No ☐
Internal Rotation							Tingling Yes ☐ No ☐
External Rotation							Decreased ROM Yes ☐ No ☐
Knee Flexion							Decreased Strength Yes ☐ No ☐
Extension							Edema Present Yes ☐ No ☐
Ankle Dorsiflexion							Splint/Brace Yes ☐ No ☐
Plantar flexion							Pain w/ Weight Bearing Yes ☐ No ☐
Inversion							Pain Interferes w/ ADL's Yes ☐ No ☐
Eversion							Weight Bearing Status NWB Toe Touch PWB WBAT

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 Fax Number: 732-562-1023

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