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

Physical Therapy Pre-Certification Form
Initial/Spinal

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 Visits **Requested**

Primary symptoms:

Duration: Frequency: ☐ Constant ☐ Intermittent

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

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

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

	Cervical Spine			**Thoracic Spine**			
	ROM Active	ROM Passive	MMT	ROM Active	ROM Passive	MMT	
Flexion							
Extension							
Rt. Lateral Flexion							
Left. Lateral Flexion							
Rt. Rotation							
Left Rotation							

	Lumbar Spine		
	ROM Active	Passive ROM	MMT
Flexion			
Extension			
Rt. Lateral Flexion			
Lt Lateral Flexion			
Rt Rotation			
Lt Rotation			

Functional Limits
Mild ☐ Moderate ☐ Severe ☐

HEP Initiated Yes ☐ No ☐

Radiculitis Yes ☐ No ☐

Parethesis Yes ☐ No ☐

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)