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

Physical Therapy Pre-Certification Form
Initial /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 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 ☐

Upper Extremity

	(Rt) ROM Active	ROM Passive	MMT	(Lt) ROM Active	ROM Passive	MMT	
Shoulder Abduction							Functional Limits
Adduction							Mild ☐ Moderate ☐ Severe ☐
Internal Rotation							HEP Initiated Yes ☐ No ☐
External Rotation							
Elbow Extension							
Flexion							
Forearm Supination							Parethesis Yes ☐ No ☐
Pronation							Tingling Yes ☐ No ☐
Wrist Flexion							Difficulty w/ ADL's Yes ☐ No ☐
Extension							Difficulty w/ Fine Motor Skills Yes ☐ No ☐
Ulnar Deviation							Muscle Atrophy Yes ☐ No ☐
Radial Deviation							Splint Fabricated 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)