Authorization Request Form - **Part 2**

# Physical Therapy (Outpatient Only)

Complete and fax the clinical worksheet immediately following the Part 1 authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

**Please fill in each question option completely** ⬭ → ⬬

## Question 1

**Which side is symptomatic? (Required, fill in all that apply)**

- ⬭ Left
- ⬭ Right

## Question 2

**Which of the following findings were documented at the most recent encounter?**

- ⬭ Neck pain, weakness, or limited motion
- ⬭ Back pain, weakness, or limited motion
- ⬭ Shoulder pain, weakness, or limited motion
- ⬭ Elbow pain, weakness, or limited motion
- ⬭ Hand pain, weakness, or limited motion
- ⬭ Wrist pain, weakness, or limited motion
- ⬭ Hip pain, weakness, or limited motion
- ⬭ Knee pain, weakness, or limited motion
- ⬭ Foot / Ankle pain, weakness or limited motion
- ⬭ Finger pain, weakness, or limited motion
- ⬭ Pelvic pain or incontinence
- ⬭ Vertigo or Poor Balance
- ⬭ None of the above

## Question 3

**What was the most recent Body Mass Index (BMI) recorded for this patient? (Required, write numeric value below e.g., "35")**